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ON WOMEN'S ISSUES

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DE L'ONTARIO SUR LA
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Women and Mental Health in Ontario

A Background Paper

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The Ontario Advisory Council on Women's Issues was established at arms-length from the government in 1973, and is in a unique position to effectively challenge the government's direction and policies. Council's mandate is to advise the Ontario government on all matters pertaining to the achievement of economic, social and legal equality for women and without limiting the generality of the foregoing: to respond to requests from the Minister for advice, consultation; to hold public meetings with the purpose of stimulating public discussion and accessing the opinions of women; to identify the specific areas requiring the attention of government and to recommend legislation and program changes to the Minister Responsible for Women's Issues. There are 15 members, all of whom are appointed by Cabinet on a part-time basis. Meetings are held in Toronto and work on identified issues is done through committees. Council brings a balance of women's views from across the Province to the government's attention.

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Preface: A Word About Language

If we were to poll all people who work in the mental health field, the one point on which there would be no dispute is that there is no definition of mental health agreeable to all. The principal Ontario government document related to mental health which is being most widely discussed in mental health circles in Ontario today, *Building Community Support for People: A Plan for Mental Health in Ontario*[1], does not even contain a definition of mental health. Throughout the report, which continues to emphasize the need for a mental health policy and a comprehensive mental health care system for Ontario, the terms "mental health" and "mental illness" are used interchangeably, with little direct attention to any real differences between the two. In a document produced by the Women and Mental Health Committee of the Canadian Mental Health Association, a definition of mental health is also lacking.

One explanation for confusion about the definition of mental health and mental illness is the persistent social stigma surrounding people who suffer from a mental illness. Harvey Simmons, in his book about Ontario's mental health policy, refers to the fact that "...despite years of effort by mental health groups, many people still think of mentally ill people as bizarre, offensive or dangerous" and adds that "the lack of public sympathy [translates] into weak support for mental health policy".[2] Lack of clear definitions can be seen as both a reflection of weak support for mental health policy or a factor contributing to it.

At the federal government level, an attempt was made to create definitions for these two terms with Health and Welfare Canada's publication of *Mental Health for Canadians: Striking a Balance*. The document acknowledges that at present there is no widely accepted definition of mental health and that much of what we know about mental health comes from the study and treatment of mental disorder. The authors state: "...most of the services, programs, laws and professions that have to do with 'mental health' are really oriented towards dealing with mental disorder". They add that "it is easy to understand how mental health has come to be viewed simply as freedom from psychiatric symptoms, or the absence of mental disorder".[3]

Several decades ago, the World Health Organization defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The creation of this definition made the important link between physical health and mental and social well-being. It helped to facilitate a view of health as more than the absence of disease. It also allowed for a vision of health which incorporated aspects of health promotion and disease prevention into our health care systems. While this is being done with increasing effectiveness in the area of physical health (e.g raised awareness about diet and cardiovascular disease, about smoking and cancer, etc.) we have not seen the same degree of health promotion activity within mental health issues. As authors of the Health and Welfare document note: "... ideas and practices concerning mental health and mental disorder have so far failed to keep pace with this emerging vision of health, which so clearly accentuates the importance of mental and social well-being."[4] This may be partly because we have been operating without a good definition of mental health and tend to continue to equate it with mental illness.[5]

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[1] Building Community Support for People: A Plan for Mental Health in Ontario, prepared by the Provincial Community Mental Health Committee, Robert Graham, Chairman; July 1988.

[2] Simmons, 1990, p xii.

[3] Mental Health for Canadians: Striking a Balance. Health and Welfare Canada: Ottawa, 1988, p 6.

Authors of the Health and Welfare document developed the following definition of mental health:

> "Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality."[6]

If we examine this definition closely, we see that it has very little to do with mental illness nor does it imply that mental health and mental illness are simply two extremes along the same continuum. What the federal definition tries to make clear is that if you are not experiencing mental health, it does not mean you have a mental disorder. A mental disorder (such as schizophrenia, manic depressive disorder, Alzheimers disease) is defined as a "recognized, medically diagnosable illness" which can result from "biological, developmental and/or psychosocial factors". It is further distinguished from a mental health problem which is seen as "a stressful imbalance among the respective demands and resources of the individual, the group and the environment".[7] Another way of seeing this is to say that one can have a mental disorder and be mentally healthy (as in the case of someone who suffers from Alzheimers disease but has strong family and community supports and feels essentially quite fulfilled). Conversely, one can be without a mental disorder and not necessarily enjoy mental health (as in the case of someone who is experiencing extreme anxiety or depression as a result of difficult life circumstances, such as a low income single mother with few job skills and no family support). In other words, "positive or negative influences can be exerted on mental health, whether the individual is mentally ill or not".[8]

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[4] op cit, p 5.

[5] For example, the division of the Ministry of Health which handles psychiatric hospitals recently changed its name to the Mental Health Facilities Branch. This may have the effect of making it easier for officials to say they are making improvements in or adding more dollars to mental health when, in fact, they are only dealing with the area of mental illness.

[6] op cit, p 7.

[7] op cit, p 8.

The authors of the Health and Welfare definition acknowledge that certain mental health problems have a mental disorder component to them (e.g when is depression truly an illness and when is it merely a survival tactic in difficult circumstances?) but their efforts to try to clarify some of the distinctions between the two would appear to be a step in the right direction. This is an ongoing issue which requires women's input.

In this report, both mental health and mental illness are examined in the context of women's lives. The author has assumed the Health and Welfare definition of mental health in an attempt to avoid the problem of using mental health and mental illness as interchangeable concepts.

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[8] op cit, p 10.

Women and Mental Health: An Overview

Even though mental health problems are not as easily discernible as most physical health problems, few people would dispute the fact that women suffer more mental illness and mental health problems than men. Although there is a great deal of inconsistency in the Canadian data available[9], women appear to outnumber men in official reporting of mental health problems and disorders and in hospital admissions for mentally related problems. They clearly outnumber men in their use of mood-altering drugs and in their use of mental health services. In certain mental diagnoses, such as depression, women outnumber men in all age categories. Women also use out-patient psychiatric and counselling services at a much higher rate than men.

Various interpretations for the sex differences in mental health problems have been put forward over the years. One theory was that women tended to talk about their problems more than men, although this has not held up against the test of scientific research.[10] Others have postulated biological reasons for women's seeming vulnerability towards mental health problems, pointing in particular to women's reproductive functions as making them more susceptible to mental illness. Women's hormones were cited as the source of the problem, and while long term research has shown the validity of some link between certain mental disorders and hormones, it certainly does not explain many of the sex differences in mental illness.

Most traditional, male-based theories of women's psychology have conspicuously failed to consider the social, economic and political forces which influence how we think and act. It took the work of the women's movement[11] to present a new view of women's psychology and to put forward the notion that women appear to have more mental health problems, not because they are inherently weaker, but because their behaviour is misdiagnosed as being "illness" and because society's prescribed roles for women make them more vulnerable to "breaking down" emotionally.

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[9] As Appendix B indicates, we do not have a clear picture of the degree of mental health problems and mental illness in women. For example, in Ontario, data from the 1982/83 census indicate that men are admitted to mental and psychiatric hospitals more often than women. 1985/86 Canadian census data show that men are admitted to hospitals for "mental disease" more often than women and stay in longer. Canadian census data for 1978/79 indicate that women suffer more mental disorders than men. The most we can conclude from this is that women suffer more mental health problems, but men are hospitalized more often for them. Any conclusions should be made with caution, however, since unlike most physical health problems, it is difficult to gather accurate statistics about mental health problems due to a stigma about mental disease and because of attitudinal biases which depend on the cultural and social setting. It is also worth noting that a great deal of improper diagnosing occurs with respect to mental health problems. As will be seen below, women may present with physical health problems when the real problem may be depression. For a thorough review of the literature on this topic, see Freda Paltiel, "Women and Mental Health: A Post-Nairobi Perspective", 1987.

[10] Mowbray et al, 1984, p. 6.

[11] Although the contemporary women's movement (from the 1960s to the present) has been most outspoken in its critique of the traditional view of women and how women are treated in the mental health field, many scholars have pointed out that women (and some men) have been talking and writing about this for centuries. For more on this, see the section on Women and Mental Illness below.

The phenomenon of women's behaviour being diagnosed as illness was put to the test by a group of researchers in Boston in the late 1960s, who produced a landmark study which questioned the biases of health professionals in working with women.[12] The group surveyed practising therapists of both sexes from various fields (psychiatry, psychology, social work) testing their hypothesis that what determines a "mentally healthy" adult will differ for adult women and men. The researchers learned that a double standard for mental health exists. When asked to describe the traits of a mentally healthy adult (sex unspecified) and then the traits of a mentally healthy adult male and a mentally healthy adult female, the attributes of a mentally healthy adult (sex unspecified) were consistently the same or similar to those for a male and different from those for females. The authors concluded that "...a double standard of health exists for men and women, that is, the general standard of health is actually applied only to men, while healthy women are perceived as significantly less healthy by adult standards. Those behaviours in women which were seen as different and, therefore, less healthy, included being less independent, less adventurous, more easily influenced, less aggressive, less competitive, more emotional, less objective, more excitable in minor crises and disliking math and science.

The authors of this study outline the dilemma faced by many contemporary women:

> "...[Women are placed in the conflicting position of having] to decide whether to exhibit those positive characteristics considered desirable for men and adults [e.g aggressive, independent, unemotional, objective, not easily influenced, dominant, adventurous, competitive, etc.], and thus have their "femininity" questioned, that is, be deviant in terms of being a woman; or to behave in the prescribed feminine manner, accept second-class adult status, and possibly live a lie to boot."[13]

The Broverman et al study has been duplicated elsewhere with similar results confirming the theory that there is a double standard present in judging the mental health of women and men. The findings of these studies are extremely important because they validate the injustice felt by many women in the mental health care system. Other feminist scholars have also questioned the notion that traits such as lack of competitiveness, being emotional, being easily influenced are labelled as deficits, rather than strengths. Jean Baker Miller, in her book, *Toward a New Psychology of Women*, points out that such classically female traits are in fact interpersonal strengths and are viewed as weaknesses only "in the context of a dominant value system which has emphasized power and separateness as signs of maturity".[14] Carol Gilligan, in her book, *In A Different Voice*, has considered that the process of moral development may be different in women than in men and rather than viewing it as inferior, as has traditionally been the case, she puts forward a strong case for viewing it as different and valuable. She argues that women have become far too accustomed to "seeing life through men's eyes" and that psychological theorists have adopted the male life as the norm and have "tried to fashion women out of a masculine cloth".[15] Critique of Gilligan's work exists; however her research is necessary to begin to bring shape and substance to women's cognitive and emotional lives.

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[12] Broverman et al, 1970.

[13] ibid, p 6.

Putting forward theories such as those of Miller and Gilligan has not been easy in a mental health care environment characterized by a masculine view of the world. As Phyllis Chesler, another outspoken advocate for a feminist view of women's mental health issues, has put it, "I would have been burned at the stake in another century. We are in a lucky century".[16] Some would not agree with Chesler's optimism. Canadian psychiatrist and author Susan Penfold noted at that same conference on women and mental health that "traditional psychiatry and the women's movement remain miles apart". In her important work, co-authored with Gillian Walker, *Women and the Psychiatric Paradox*, Penfold shows how "prevailing psychiatric doctrine has played an active part in perpetuating women's oppression... Theories of mental health... have always reflected and reinforced social, political and economic trends, and have been used as a form of social control serving to limit troublesome people in our society". She maintains that "psychiatry, in representing women as diseased and disordered [is] papering over the distress and damage caused by the society in which we live".[17]

The notion of "social control" has also been used to describe the extent to which women are prescribed mood-altering drugs to cope with emotional problems. While the element of social control exists for both men and women, it is important to keep in mind women's over-representation in psychiatric wards and as recipients of prescription drugs. As noted in the Ontario Advisory Council on Women's Issues brief to the Pharmaceutical Inquiry of Ontario (Lowey Commission,1989), "women are prescribed twice as many psychotropic (mood-modifying) drugs to deal with depression as men and receive 73% of all prescriptions written for psychotropic drugs, although they make up just over half of all visits to doctors' offices".[18] Both Canadian and American research has shown that women receive significantly more prescriptions for psychotropic drugs than do men who present to a physician with similar emotional problems.[19]

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[14] Webster, D., 1988, p 29.

[15] Gilligan, C., 1983, p 6.

[16] Phyllis Chesler, in a keynote address to the Canadian Mental Health Association conference on Women and Mental Health, Banff, Alberta, May 11-14, 1989.

[17] From the proceedings of the CMHA conference on Women and Mental Health, Banff, Alberta, May 11-14, 1989.

Recent indications from women's shelters in different parts of Canada show that an alarming number of women who are in abusive relationships and coming to shelters for care are being given mood-altering drugs by physicians. A study conducted by the Addiction Research Foundation found that women who are beaten by their partners are 74% more likely to rely on mood-altering drugs and 40% more likely to take sleeping pills.[20] Perhaps in the belief that they are helping women to cope, physicians are contributing to a woman's state of helplessness and powerlessness by numbing her feelings. While there are admittedly valuable uses for psychotropic drugs, this one is currently being questioned by some shelter workers.[21] A recent study of the Addiction Research Foundation also found that the use of prescription sleeping pills, stimulants and tranquillizers is on the rise in Ontario among women between the ages of 18 and 29.[22]

Critics of the psychiatric model have also taken issue with the DSM IIIR (Diagnostic and Statistical Manual), used by mental health practitioners around the world to diagnose psychiatric disorders. As Paula Caplan noted in her presentation entitled "Calling Normal Women Crazy" at the Canadian Mental Health Association (CMHA) conference on women and mental health, "the problem is that the Manual is almost universally accepted within the mental health professions - psychiatric residents read it to pass exams and take it as literal truth, while health insurance administrators require a DSM diagnosis as a condition for payment". When the creators of the DSM, the American Psychiatric Association (APA), announced that they were planning to include a new diagnosis entitled Masochistic Personality Disorder, a few years ago, the feminist therapy community in Canada and the United States was up in arms. Caplan paraphrased the definition of the diagnosis as describing "an individual who puts other people's needs ahead of her own, continually settles for less, and feels unappreciated", a description which would describe the reality of many women's lives. For many, this diagnosis, which was clearly meant to be used mostly on women (in spite of the APA's claims that it was "gender-neutral"), and more specifically would be used to "diagnose" women in abusive relationships, reflected the male bias of many psychiatrists in wanting to turn the harsh realities of many women's lives into mental disorders. In spite of tremendous opposition (including hundreds of thousands of signatures on petitions), the diagnosis was accepted and is now part of the DSM IIIR.

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[18] Archer et al, 1980; Cooperstock & Hill, 1982; Harding et al, 1978; Women and Mental Health Committee, 1987; Eichler et al, 1988.

[19] Bass, 1981, p 1211.

[20] Fine, August, 1989, reporting on a study by Judith Groeneveld and Martin Shain of the Addiction Research Foundation.

[21] Based on comments from a number of participants from across Canada at the CMHA conference in Banff, 1989.

[22] Fine, 1989. The study also found that cocaine and cannabis use, as well as binge drinking, are on the rise for women in this age group in Ontario.

It is against this backdrop of an on-going trend in traditional psychiatry to pathologize women's lived experiences, that others are increasingly questioning long-standing assumptions about women. New findings are emerging which may radically change the face of women's mental health care as we have known it. Most noteworthy is a growing awareness of a link between a number of mental health problems in adult women (in particular, addictions and eating disorders) and an earlier history of sexual assault and abuse.[23]

As this type of research becomes more widely recognized and as women who have suffered these experiences come forward in larger numbers, we can hope to see a continued questioning and transformation not only of treatment services for women but of the very forces in society which put women at such a distinct disadvantage.

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[23] In Winnipeg, when a group of women working in addictions treatment services for women noted the high incidence of earlier sexual abuse, they went on to establish a centre specifically to help women coping with this childhood trauma. (The Women's Post Treatment Centre)

The Lives of Women

Until roughly the 1970s, research which looked at women and their mental health tended to focus on life events to explain why women were disproportionately represented in psychiatric wards, as recipients of prescription drugs and as victims of depression. This orientation examined single events or stages in a woman's life which were usually related to biological events (childbirth, menopause) or family structure, and viewed these events as being the cause for a lack of mental well-being, with a particular focus on the dynamics of dealing with change. While life events and dealing with change may be one factor in determining women's mental health, many believed it did not tell the entire story. Feminist scholars began to question this orientation and a proliferation of literature grew in the 1970s and '80s. A feminist orientation looked more at the conditions of oppression in women's lives - such as sexism, lack of money, the isolation of the childrearing role and abusive relationships - rather than isolated incidents or life changes. These long-standing (for some, lifelong) conditions were found to be far more significant determinants of women's mental health and well-being. As it was summarized by a group of American researchers: "...an environment which allows women little control over most of the important things in life and little hope that life will improve...(and) the long-term problems of poverty, burdensome responsibilities, and foreclosed opportunity, contribute more heavily to the depression of low-income mothers than a single crisis or tragic event".[24]

A consideration of the factors which contribute to women's second class status in society has been referred to as the social organization of women's lives. How that social organization is defined can determine whether a woman's reaction to it is seen as simply an expectable and appropriate response (a survival strategy, as one interviewee put it) or a mental illness. This response will then shape the further and future social organization of her life. This section of the document will look at the social organization of women's lives and those factors which have a particularly strong impact on women's mental health.

A. Factors Which Shape Our Mental Health

1. Violence Against Women in Our Society

Figures about the extent of violence against women in our society vary to some degree but available research points to an alarming prevalence of female victims of male violence. One out of every eight to ten Canadian women is physically, psychologically or sexually battered by her spouse or partner[25]. In her landmark study for the Canadian Advisory Council on the Status of Women, *Battered But Not Beaten*, Linda MacLeod also reported that for every woman accepted at a transition house in Canada, one is turned away. One Toronto transition house reported this figure to be as high as ten turned away for every one accepted. The impact of wife battering on one's sense of self-esteem can not be over-estimated. As MacLeod has stated the situation: "To be a battered woman is, by definition, to be isolated, to have few friends, often limited access to money and to be trapped in a cocoon of secrecy".[26]

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[24] Belle at al cited in Lilith Research Consultants, p 7 (Appendices).

[25] MacLeod, Linda, 1987, p 7.

Violence against women also takes the form of sexual assault (or rape[27]), for which Canadian figures tend to be around one in four women. It can take the form of rape by a stranger, rape within marriage or "acquaintance rape" (including date rape, rape by supervisor or employer, friend, or colleague).

An extensive body of literature is developing regarding the psychological aftermath of sexual assault and ongoing abuse. Mental health problems commonly suffered include:

- depression
- fear, terror
- anxiety
- feelings of betrayal, guilt, anger humiliation and powerlessness
- self-destructive behaviour, including suicide attempts
- sexual problems
- phobias
- substance abuse
- low self-esteem
- difficulty with interpersonal relationships
- sleep disorders
- eating disorders

Incest[28] is another form of violence against women. We are learning a great deal about the mental health of the girls who are victims and about the women they become. The overwhelming majority of incest perpetrators are males (98.8%) and yet, interestingly, a major federal study of sexual offenses against children[29] barely dealt with this fact in its recommendations. Lorenne Clark, in a critique of the federal report, noted that the authors "...feel no need to state and pause over the fact that it is males who are overwhelmingly responsible for this state of affairs. Nor do they discuss why this is so and how it can be changed. They seem simply to assume that, of course we realize this, as of course we all do, realizing as we do that boys will be boys, after all."[30] In her extensive study of father-daughter incest (by far the most common form of incest), American feminist psychiatrist Judith Lewis Herman states the need for a feminist analysis of this issue which has for so long been shaped by Freud's interpretation.[31] She writes:

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[26] op cit, p 22.

[27] Although the legal term in Ontario is now "sexual assault", rape is an important word to maintain. Feminist author Susan Griffin defines rape this way: "Rape is an act of aggression in which the victim is denied her self-determination. It is an act of violence which, if not actually followed by beatings and murder, nevertheless always carries with it the threat of death... Rape is a form of mass terrorism, for the victims of rape are chosen indiscriminately, but the propagandists for male supremacy broadcast that it is women who cause rape by being unchaste or in the wrong place at the wrong time - in essence, by behaving as though they were free". (Griffin, 1979, p 21)

[28] In her book, Conspiracy of Silence, Sandra Butler defines incest as "any manual, oral or genital sexual contact or explicit sexual behaviour that an adult family member imposes on a child, who is unable to alter or understand the adult's behaviour because of her/his powerlessness in the family and early stage of psychological development". Mike Lew, author of Victims no Longer (Harper & Row, 1988) offers this definition: "Incest differs from other forms of sexual abuse in that the perpetrator is assumed to stand in a protective (parental) role to the victim. The very person that the child should be able to turn to for care, comfort, and understanding violates that trust by sexualizing the relationship. For this to be a traumatic experience, it is not necessary that the "parenting" figure be a family member. Children naturally trust those adults who are closest to them -- until there is reason not to. Sexual exploitation by any older caretaker is by definition incestuous because it destroys that natural trust. This is true whether the perpetrator is a relative by blood or

> "It is not possible to write dispassionately about incest. The subject is entirely enmeshed not only in myth and folklore, but also in ideology... Without an understanding of male supremacy and female oppression, it is impossible to explain why the vast majority of incest perpetrators (uncles, older brothers, stepfathers and fathers) are male and why the majority of victims (nieces, younger sisters and daughters) are female. Without a feminist analysis, one is at a loss to explain why the reality of incest was for so long suppressed by supposedly responsible professional investigators, why public discussion of the subject awaited the women's liberation movement, or why the recent apologists for incest have been popular men's magazines and the closely allied, all-male Institute for Sex Research."[32]

2. Women's Economic Status

There is a growing body of literature to support the hypothesis that poverty puts one at risk for mental health problems. This is not meant to imply that if one is poor, one will necessarily have mental health problems or that all people with mental health problems are poor. As the federal government document *Mental Health for Canadians* explains: "Not only

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marriage, parent, stepparent, older sibling, neighbour, family friend, teacher, member of the clergy, therapist, physician, baby-sitter, camp counsellor, or any other caretaker. In all instances the child's world becomes unsafe -- confusing and frightening."

[29] Badgley, Robin. Sexual Offenses Against Children. Ottawa: Canadian Government Publishing Centre, 1984.

[30] Clark, 1985, p 8.

[31] Freud claimed that little girls fantasized about having sex with their fathers.

[32] Herman, 1981, p 3.

can poverty limit a person's capacity to alter the environment... it can also inhibit the full use of his or her mental and behaviourial abilities [and] can interfere in countless ways with the attainment of individual and community goals, and with the exercise of human rights".[33]

In Canada, overall, women are poorer than men. Women still earn only 66 cents to every dollar earned by men[34] and many women remain economically dependent on men due to social stereotypes about who is the most appropriate caregiver. Women comprise 3/4 of the part-time labour force[35] and all the economic insecurities which go along with that. Women's work in the paid labour force tends to be segregated in the low-paying, low-status occupations, a fact which is related to a higher incidence of low self-esteem and depression.

In 1987, of Canadians who were classified as having low incomes (defined by Statistics Canada as below $13,400.) 42% were women and 32% were men. In Ontario, as elsewhere in Canada, single parent families headed by women are on the increase and represent roughly 1/3 of all poor families in Canada.[36]

The situation for many women in Ontario was summarized through the public awareness campaign of the Social Assistance Review Committee (SARC) following the release of its report in 1989:

> "TRANSITIONS, the report of Ontario's Social Assistance Review Committee, has shown us a different - and alarming - Ontario. It is not the province of prosperity and opportunity known by the majority of us, but a place whose most vulnerable citizens - the disabled, and single parents, 85 per cent of them women - depend on inadequate social assistance in order to live. In this other Ontario, half a million people, almost half of whom are children, exist in inadequate housing and are poorly clothed, fed and educated. Perhaps the most disturbing of all, they are being deprived of hope."

Indeed, many of the poor described in the report are further being deprived of hope by the lack of attention being given to the Report's recommendations. While the SARC Report was a promising start to reform for Ontario's women, the implementation of the recommendations have been very slow in coming. Lobby groups are still working hard to convince provincial officials to act on these pressing issues. And pay equity legislation in Ontario, while aimed at increasing women's wages, is unfortunately not yet relevant for women in the lowest paying and least protected sectors of the work force.

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[33] Mental Health for Canadians: Striking a Balance, 1988, p 13.

[34] Statistics Canada, Catalogue No. 13-217, 1987.

[35] Women's Bureau, Labour Canada, 1986.

[36] Ross and Shillington, 1989. pp 23 & 41.

That sense of hopelessness and the experience of one's work continually being undervalued and unappreciated contribute to mental health problems for women. Finally, women have a greater life expectancy than men and we know that poverty increases with age, particularly so with women.

3. Women's Work

Even though women's participation in the paid labour force has increased markedly over the past twenty years[37], women still assume the bulk of home and family responsibilities, regardless of whether they are in the paid labour force.[38] This is due to the fact that women's work in the home has traditionally been undervalued and it has been assumed that this is the work of women. The "invisible" work for which women have long assumed major responsibility includes not only housework and the care of children, but the care of aging parents, care of sick family members, responsibility for family nutrition and health care as well as the overall psychological well-being of family members.[39] The stress created by these pressing responsibilities takes a tremendous toll on women's mental well-being.

In a study for the Canadian Advisory Council on the Status of Women released in 1986, Anita Fochs Heller wrote about how women's role of "health guardians" is in fact providing the system with a great deal of free health care services. She also discovered that, often, women do not look after their own physical and mental health because they are too occupied looking after the health and well-being of others.

In her talk at the Ontario Advisory Council on Women's Issues' conference on motherhood in a changing society, Maureen Kellerman, founder of a support group for mothers who stay at home, summed up the picture for women in this situation:

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[37] Female participation in the paid labour force since 1970 has risen 10%. The largest increase in participation rates has been with married women with children under the age of three. (Historical Labour Force Statistics. Statistics Canada, 1988)

[38] Statistics Canada data indicate that women, whether employed in or outside the home, still assume more responsibility for household tasks. In the area of meal preparation, for example, 77% of women prepare family meals on any given day in comparison with only 29% of men. It was found that women tend to spend more time at any given household task than do men. (Canadian Social Trends (Statistics Canada), Spring, 1990)

[39] This is not meant to imply that this work is only done by women but traditionally it has always been viewed as "women's work" and, as noted above, women still do the bulk of it. While more and more men are assuming some of these responsibilities, change is very slow.

> " Some have a sense that they are no longer part of the real world, that they are on the sidelines. Many have concerns about losing marketable skills and about their ability to re-enter the workforce. And some have concerns about losing their sense of an independent identity separate from family. But by far the strongest consensus about women at home is that being a full time mother lacks status. Most feel that there is a general societal pressure to work outside the home, an implicit message that any reasonably intelligent, reasonably well-educated woman would not spend any significant period of time at home raising children."[40]

Kellerman also dispels the myth that women who stay at home with their children are in relationships where a husband earns a substantial income and the woman doesn't "have to" work and are "privileged". In fact, she notes, most families where a mother is staying at home are having trouble making ends meet. Women are ultimately damned if they do and damned if they don't when it comes to working inside or outside the home. Kellerman notes the societal disapproval of stay-at-home mothers. Others have noted the stigma they felt as a mother who works outside the home, faced with endless societal messages about the damage done to children by childcare and the "selfishness" of women who do not choose to stay at home. All of this contributes to stress and confusion for many women.

Furthermore, women suffer from what one author calls "maternity controls", by which institutions of social control (psychiatry, the social welfare system, etc) judge women in relation to their mothering roles. Penfold explains:

> " Women who do not fit with the ideal of the married stay-home mother who happily cares for perfect children meet with considerable stigmatization and devaluation - for instance, the voluntarily childless wife, the unmarried mother, the working mother, and the mother who is having problems with childrearing or who is thought to qualify for the term "unfit mother""[41].

The work done by women in the home is not without its rewards, but for many women the social and economic factors which surround the work can leave them feeling isolated, exhausted and powerless. Freda Paltiel has noted that "... the relationship between women's work and women's worth has profound consequences for their mental health". The caring role which women play in the home also restricts their opportunities in wider society and reinforces their economic dependence. Both factors can contribute to a sense of worthlessness and depression. A wide range of studies have substantiated the finding that depression is most common in women in their childbearing years and at its highest rate in women at home with young children.

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[40] Proceedings from "Motherhood in a Changing Society" conference held by the Ontario Advisory Council on Women's Issues, June, 1988, p 106.

[41] Susan Penfold, Depending on Ourselves, 1986, p 7.

On the job, in addition to occupational health hazards faced by both sexes, women also face sexual harassment, and additional fatigue resulting from their responsibilities in the home. These health hazards put women at an increased risk for mental health problems. Inadequate subsidized day care facilities, the disruption of family life caused by shift work, and lack of benefits for part-time work are additional stresses faced by women in the paid labour force.

4. Sex Discrimination

In spite of notable advances made, women still experience considerable discrimination on the basis of their sex. Discrimination takes the form of paying women less than men, objectifying women sexually, not acknowledging the financial value of work done in the home, preferring men over women in employment situations, and assuming that women are the ones responsible for care of family members. It is also manifest in such things as lack of women's appointments to positions of power and authority and inadequate childcare facilities. There is now a growing body of literature to indicate that discrimination can have profound effects on one's mental health. The sense of powerlessness one feels as a result of being discriminated against can, and very often does, lead to depression.

Because women have made some advances in eliminating sex discrimination (through moving into political positions and positions of power in the work force) the public is often duped into believing that sex discrimination is no longer an issue. There need to be constant reminders that only few women find themselves in such privileged positions and even when they attain these positions, they often experience more subtle forms of discrimination on the basis of their sex. Those working in underpaid jobs, in factories, retail service, in rape crisis centres and shelters for battered women, in non-traditional occupations and within the mental health field provide ample testimony to the fact that many Canadian women experience a good deal of sex discrimination.

The existence of this discrimination and the need to protect women from it were acknowledged by the inclusion of equality guarantees in the Canadian Charter of Rights and Freedoms in 1982 (Sections 15 and 28[42]). Challenges and invocations of the Charter, as demonstrated by the work of organizations such as L.E.A.F. (Women's Legal Education Action Fund), are beginning to influence the social organizations and interpretation of women's lives.

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[42] Section 15 reads: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability" (Subsection 1). Section 28 reads: "Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons".

5. The Socialization of Girls and Women

In western culture, as in most cultures, young girls are taught that appropriate behaviour for them involves being nice to others, avoiding conflict, never showing anger or aggression and that such behaviour will be rewarded.[43] Girls and women are taught to put the feelings of others before their own. We need only look at how female-dominated most of the care-giving fields are for evidence of this social reality. The extent to which this process forms one's identity and one's sense of self-worth is considerable.

Toni Laidlaw, sociologist at Dalhousie University noted at a conference on women and mental health in Banff in 1989, "The socialization to be feminine is a physically, spiritually and psychologically crippling process. We are taught to be passive, dependent, selfless, to defer to men at the expense of devaluing ourselves and other women, to care for and nurture others without nurturing ourselves, to be dissociated from our bodies and our feelings, to be objectified, to assume responsibility for the sexual denigration and violence done to us. The paradox of feminine socialization is that it is impossible to be simultaneously a 'proper lady' and a healthy human being".[44]

Some have argued[45] that in fact, socialization for young boys is even more rigid than for young girls and that they must operate within an even narrower range of appropriate behaviour with respect to their sex roles (e.g "Don't be a sissy", "Little boys don't play dress-up", "Show your stuff", "Don't play with the girls"). However, Mowbray et al have noted that "beginning in adolescence (age 15 years and up), females experience more stress as well as mental health problems from the need to abandon masculine activities (like achievement), from increased pressure to adopt the feminine role, and from greater awareness of males' favoured status".[46]

The end result of the socialization process experienced by most girls and women is that "women have a more negative orientation toward themselves than do men [and] judge their shortcomings on the basis of deeper, more individual qualities".[47]

6. Nutrition and Environment

Few people would argue with the statement that there is a relationship between physical and mental health. The relationship works both ways. For example, the extent to which both chronic and life threatening physical health problems can contribute to depression has been well documented. At the same time, acute stress can result in such physical health problems as irregular heart rhythms and even sudden death. Whether it is the physical affecting the mental or the mental affecting the physical is not always completely clear. It has been noted that "the immune system connects with the nervous system in infinitely intricate ways".[48]

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[43] Expressions such as "Don't you worry your pretty little head" or the French "Soit belle et tais-toi!" exemplify this.

[44] Women and Mental Health: Social, Economic and Political Perspectives (Summary Report), 1989, p 45.

[45] A noteworthy book on this topic is Every Mother's Son: The Role of Mothers in the Making of Men. Judith Arcana. London: Women's Press, 1983.

[46] Mowbray et al, 1984, p 10.

[47] Mowbray et al, 1984, p 9.

There is, however, considerable debate about the extent of the relationship between the two within the medical community. It has tended to be other health professions - psychology, nutrition and various alternative health disciplines - which have been more receptive to exploring that relationship further and working with different ways to alleviate both physical and mental suffering. It is not surprising that women tend to be the major consumers of alternative health therapies and self-help literature.[49] As the primary "health guardians in the home", women are more likely to notice that certain foods make a child more active or lethargic, that perhaps it is the ventilation system which is causing everyone to catch colds or that an adolescent's moodiness might be helped by more physical activity. As primary users of the health care system, women are also more likely to be the first ones frustrated by the limitations of western medicine with its focus on body systems and how to "fix" them, rather than a more holistic approach which characterizes many of the alternative health practices. Toronto health activist Maggie Burston has noted that

> "Women are not "alive and well" in Canada, and the fault is not their own. They are suffering from the effects of environmental pollution, work speed-up and contemporary medical practices."[50]

Burston has suffered for a good part of her adult life from a condition called **candida albicans** or what she calls "environmentally induced immune disregulation". Her condition is worth noting in the context of women and mental health because it is four times more common in women than men. It is very difficult to diagnose and women often wonder if they have just imagined they have something wrong. The condition is characterized by recurring vaginal yeast infections and cystitis (bladder infections), extreme food and environmental allergies, irritability and depression, short term memory loss and confusion, indigestion, lethargy and menstrual problems. Being immunological in nature, it is believed to affect women more commonly than men because of its heightened responsiveness to hormones (birth control pills usually provoke or exacerbate the condition).[51] It is not known to what extent the psychological symptoms are the result of trying to cope with the debilitating physical symptoms or actually part of a systemic immune dysfunction which affects the brain. Treatment usually involves use of an anti-fungal medication and major dietary change including supplementation to enhance the immune system.

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[48] Dr. Margaret Thurling, of the Women's Clinic, Department of Psychiatry at the Wellesley Hospital in Toronto, quoted in an article on women and stress (Wysong, 1990).

[49] Heller, 1986.

[50] Burston, 1989, p 10.

[51] Bland (date unknown).

Another immune system disorder also found much more frequently in women and linked to high levels of depression is **chronic Epstein-Barr virus** (also known as **chronic fatigue syndrome, post-viral neuromyasthenia** and **myalgic encephalomyelitis**). Considerable controversy surrounds this condition, referred to in the media as "yuppie flu" and characterized by chronic fatigue. The cause is not known - some research shows the condition as a virus, other as an immune system disorder. A remarkably high percentage of individuals with the condition suffer from varying degrees of "diagnosable psychiatric disorders"[52]. Some have maintained that the high level of depression among those who have the condition should characterize Epstein Barr as a psychosomatic condition. One author went so far as to say that women get the disease more than men "because they are nicer" and that being nicer is linked to higher rates of depression, etc..[53] Traditional medicine has yet to find a "cure" for the condition, but many have been helped through dietary change and visualization and imagery techniques.[54]

Debates continue in the health care community about the relationship between the physical and the psychological, between the environment and the immune system, between nutrition and the immune system and between nutrition and mental health. What appears to be a constant is that women are suffering from an inordinate amount of environmental, nutritional, and immune-related mental health conditions and that they are increasingly seeking self-help and alternative methods to deal with them.[55]

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In addition to those factors which constitute the social organization of women's lives and contribute to their second class status, the life phases and life events of women's lives can also have a very significant impact on their mental health. These includes such experiences as pregnancy, birth, infertility, motherhood, separation, divorce, menopause, loss of a job, illness, unemployment and widowhood. It is important, however, that they be examined not simply as single life events but in the context of other elements of a woman's life.

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[52] Greenberg, 1990.

[53] Holland, 1990.

[54] Rotenberg, 1989, p 24.

[55] Editorial, Healthsharing collective, Healthsharing, Spring, 1989.

B Women Who Experience Additional Isolation and Discrimination

1. Native Women

Contacts made with the Native Mental Health Association of Canada (Shannonville, Ontario), the Native Mental Health Program at the Zone Hospital in Sioux Lookout and the Ontario Native Women's Association revealed very little information on mental health specific to women. For reasons undoubtedly rooted in Native culture, distinctions between the sexes are not commonly made in most of the literature about Native mental health issues which was unearthed for this report. For example, in proceedings from four annual meetings of the Native Mental Health Association of Canada very infrequent reference is made to wife assault, with consistent preference given to the terms domestic violence and spouse abuse. Similarly, research data presented at these meetings in the form of tables and charts (e.g. incidence of depression, suicide) rarely showed a break down by gender.

Simply by virtue of being a Native person living in Canada, there are a number of factors which contribute negatively to one's mental health. These have been outlined in a number of sources:

> " Ever since Indian people have been forced to live within the confines of government owned and administered reserves, they have struggled with powerlessness, all-encompassing racial discrimination, epidemic high unemployment and extremely crowded and inadequate housing. They have endured for generations such symptoms of oppression as rampant poverty, depression, alcoholism, family violence, suicide and poor health. At the same time the various cultures of Indian peoples, the foundation of their identities have been and continue to be in radical transition."[56]

In addition to these factors common to all Native peoples, women face additional burdens and hardships which affect both their physical and mental health.

- An alarming number of Native women are the victims of some form of abuse. A study conducted by the Ontario Native Women's Association in 1989 found that abuse was experienced by eight out of ten Indian and Métis women, usually at the hands of their husbands. Louise Sinclair of the Native Mental Health Program at the Sioux Lookout Zone Hospital noted in a presentation in 1987 that women who have been abused and are brought into the hospital from their communities tend to be mostly young married women with children. Suicide attempts and depression are very common in the group they see. The extent of alcohol abuse among perpetrators appears to vary from community to community.[57] One Native woman who also spoke at this presentation, and works as a counsellor with battered women in the Zone Hospital, told of her own experience in saying: "I saw so many battered wives that I thought this was marriage, this was a way of life."[58] Sinclair also commented on how difficult it is to gather this information. When a questionnaire was circulated to CHR (Community Health Representatives) in the Zone region - all of whom are Native - none answered the questions about wife abuse. The information they have gathered has tended to come from outsiders who have gone into the communities.

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[56] Whipp, 1985. p 1.

- Nineteen percent of Native families are headed by single parents, the vast majority of these women.[59] Both single parent and married Native women also tend to have larger families than non-Native women. This can create financial burden and fewer opportunities for employment where childcare is unavailable.

- Employment levels for Native women both on and off reserves is lower than for Native men and lower than non-Native women.[60] 1981 census data indicated that 67% of Native women in Ontario had annual incomes of less than $5,000, including those with no incomes. Their average incomes were considerably lower than those of both Native men and non-Native women.

- The role of childbearing is central to women's identity in many Native communities.[61] Increasingly, women are being deprived of their ability to give birth with Native midwives in their communities, but instead are flown out to urban centres prior to their delivery date. Traditional Native birthing customs are being replaced by hospitals and modern technology. While some sources indicate that this has contributed to a decline in infant and maternal morbidity and mortality rates, the impact on many women has been devastating. Families are separated, women are often lonely and isolated and are forced to deliver their babies sometimes with caregivers who are insensitive to Native birthing customs.

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[57] Kathleen Whipp, a former student in the School of Social Work at Carleton University, in a critique of three studies of wife abuse in the Native community, noted that issues of alcohol abuse, community disintegration, unemployment were overemphasized as causal factors. She notes that "...the issue of why men choose to beat their wives, rather than act out their frustrations in other ways, is crucial. There must be an awareness on the part of policy-makers, social service personnel, and community members who read these and similar reports that subtle omission and over-emphasis can reinforce the problem of denial of male dominance through abuse of women". (Whipp, 1985. p 32)

[58] Louise Sinclair and Sally Rae in Family Violence: A Native Perspective, pp 41-42.

[59] Nicholson, J.P. (1987), p 15.

[60] ibid, pp 24-25.

[61] Malloch (1989) writes of the sacredness of women's reproductive power in the Native community and notes that women are seen as having "great natural healing power that derive from her spiritual connection with the Earth".

- Women affected by Bill C-31, (the bill revoked the discriminatory Indian Act clause which stripped Native women of their status upon marriage to non-Indians while granting status to non-Natives who marry Indian men), have faced discrimination and rejection from some of the communities to which they have returned. Some chiefs and councils have fought against having this group of women re-instated. Consequently, these women have been viewed as outsiders in their communities and unworthy of benefits and services accorded other status Indians.

- Native women account for 30% of the inmate population at the federal Prison for Women in Kingston[62],[63]. Because this is the only federal prison for women in all of Canada, women from all parts of the country are sent there and inflicted with what some consider to be the unjust punishment of having to be far away from home and family.[64] It has been suggested that the disproportionate number of Native women incarcerated may be a reflection of "prejudiced or discriminatory application of the law and/or...systemic discrimination within the law itself".[65] In describing the profile of Native female offenders, author Holly Johnson is describing the same conditions which put women at risk for mental health problems:

> "Large numbers have been victims of physical and sexual abuse, and many are emotionally or financially dependent on abusive male partners... For the most part, women in conflict with the law are non-violent offenders who commit petty crimes of economic gain. Their offenses are concentrated in the types of property crimes that could well be considered means of survival in a time when employment options for unskilled women are becoming increasingly restricted."[66]

- Native women living in urban areas face the overt discrimination faced by other visible minority groups (including the increased likelihood of sexual violence) as well as a lack of easily identifiable social services geared to their needs.

One Native woman who conducted the opening ceremony at a conference on depression in the North American Indian in 1986, spoke of her own personal story with respect to depression. Excerpts from her story provide some insight into factors which may have an impact on the mental health of Native women more generally.

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[62] Halferdahl, 1989. p 4.

[63] In September 1990, Correctional Services Canada announced a 4-year plan to decentralize the federal prison for women. The plan includes building 5 regional (across Canada) federal penitentiaries and relocating women serving prison terms at the Prison for Women in Kingston.

[64] In Saskatchewan recently, a Native woman who was several months pregnant and convicted of homicide and sentenced to time in Kingston, was allowed to be sent to the provincial prison after her lawyer argued successfully that it was inequitable and unjust treatment and constituted discrimination on the basis of sex. Already this year, two Native women at Kingston have committed suicide.

[65] ibid. p 16.

[66] cited in Halferdahl (1989), p 32.

> " I was raised on the Reserve and I found some real good happy life while I was with my father and mother at home. I knew they loved me even though we had an old log house. ...That was before I went to school. I had to go to a residential school and this was a Catholic school. If we didn't go to school, our parents could go to jail and so they sent us to school or the law would get after them... I was very, very lonely. I didn't understand why they left me there but right from that day the bittemess started coming in, that hateful resentment...there was a lot of fighting, back-stabbing, picking on one another in the school. I became one of these people that would rather be by myself. You lock yourself away in order to stay out of trouble. The rich girls used to dominate the other girls and I was not one of the rich girls... My mother died when I was eight years old... and all I knew was aunties and uncles that I could go home to when we were allowed to go home from the school. Those were not very good experiences... There was no love there... I became really bitter. I started hating... I was forever being punished... I started my mistrust for people... When I was 14 years old, I started to be ashamed of me, Rose. I started hating God then because why did he put me on this earth to look like a freak?... I never saw the good side of people, but I saw all the bad sides. I ran away from school to the States at 15 years of age... and that is the first time I had a drink... I returned to the reserve and there... a woman has to be a Saint or almost a Saint and I was not like that any more... You have to have a husband if you are a woman; if you don't... then you are the most talked about woman there... I was unhappy so I went and lived with a man who I didn't even love, never knew him, just met him... At first I didn't drink with my husband but when he drank, he was one of the meanest people you could find. He beat me up and... I didn't know how to fight for myself. When I was hurt, I couldn't tell anyone, I just stayed home and got healed up. When he was sober, he was very nice to me and I didn't understand what was going on. As time went on, I started drinking. Then I found I needed to drink, I found I could be happy with a few drinks and I could fight and I could stand up for myself, I could do things I wanted to do."[67]

She goes on to say that she discovered Alcoholics Anonymous and is now well on the road to recovery. Her story is not meant to leave the impression that every Native person's experience in residential schools was negative or that all Native women have a problem with alcohol. But many of the conditions of her life are not that dissimilar to those of a number of Native women and provide some understanding of why Native women are at risk for developing mental health problems.

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[67] Rose Yellowfoot in Depression in the North American Indian: Causes and Treatment, pp 4-7.

Given that we know that depression is generally more prevalent in women than in men, we can assume that this is probably so for Native women as well. Joyce Timpson of the Mental Health Program at the Zone Hospital in Sioux Lookout has noted that 90% of the people they see in the program are there because of depression. She adds that Native people experience a great deal of tragic death and that many of the old ways of grieving have been lost. The inability to grieve or cry for a lost one is seen as a major contributor to depression in Native people.[68] Whereas in the past family members might bear more responsibility for helping a fellow member through a depressive period, one elder noted to one of the Zone hospital workers that the Natives' loss of their culture[69] and sense of importance of the spiritual has changed that relationship for the worse. Cases certainly exist of people having been helped by medicine men practising in the North after medical, non-Native methods have failed.

Dr. Clare C. Brant, who is a Mohawk Indian, a psychiatrist and the Chair of the Native Mental Health Association of Canada has noted that "Native people, in [his] experience, do not complain about unhappiness unless it is extreme and often seem to be engaged in a contest about who can endure the most without complaint." He goes on to say that "... anger is probably the most difficult emotion with which the Native person deals", adding that "the reasons for this are legion but anger probably was a threat to the cohesiveness of closely-knit tribal groups who required co-operation to survive in a hostile environment. Strong expressions of anger were, therefore, suppressed and to many this meant... the angry feelings were kept totally out of consciousness or projected onto the spirit world... Anger turns into depression especially in Native people because we have lost many of our boogie men onto whom the rage used to be projected. The only boogie men left in our lives are the white men and heaven knows they have enough trouble of their own. We are hence left to gargle in our own rage and depression."[70]

Dr. Edward Connors, a Native psychologist working in the Kenora area and strongly involved with the Sacred Circle, a suicide prevention service for children and youth up to the age of 24, spoke at the meeting of the Native Mental Health Association in 1989 about the fundamental reason for the extent of mental health problems in the Native population:

> "The formation of values and beliefs are central to the establishment of mental health. A life without values and beliefs is void of direction and meaning. In the present day, Indian families face many challenges on their paths to a healthy future. One of those challenges is determining which of the many paths presented to them they are going to follow. The different paths presented are

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[68] Joyce Timpson in Depression in the North American Indian: Causes and Treatment, pp 47-49.

[69] This is described in the proceedings from the conference as "anomie" or "a loss os sense of who one is and what place one has in the society one lives in".

[70] Dr. Clare C. Brant in Depression in the North American Indian: Causes and Treatment, pp 32-43.

> made up of a variety of different values and belief systems. The major values and belief systems presented to the Native person are those from the dominant culture and the traditional ways of Native people.
>
> The value and belief system of a dominant culture appears to be heavily structured by ... a search for cause and effect or linear thought. The value and belief system of the Anicinabi is heavily influenced by holistic things which can also be called the theology of ecology, a recognition of the whole as opposed to the parts. Many Indian families are caught in the transition between these two values and belief systems, unable to live either one of these systems completely. The Indian family is left in a dilemma, attempting to integrate and draw from these two value and belief systems."[71]

A psychiatrist in British Columbia who has worked with a number of Native women has spoken of her experience in observing their "tremendous ability to recover from depression". In wanting to understand "what it is that gives these Indian women the strength to carry on", she circulated a questionnaire from this exercise and concluded that "they have much more intensive human contacts both negative and positive during the growing years". She found that "there always seems to be somebody in the Indian community who can help the child emotionally whether it is a neighbour or a family member or some other strong person... Through some words or some gesture of love that child has been able to carry on in a very positive way. There seems to be a feeling that life goes on anyhow in spite of all the unhappiness. There is a natural feeling that life has to be preserved. Nature is surrounding the Indians... and nature has a very positive effect on mental health; the beauty of nature and then the Indian tradition, be it ever so little that is preserved... what is left of the Indian teachings is very positive for the mind."[72]

This description points to what is at the core of most if not all problems of a health and social nature in the Native community - the absence of self-determination and self governance by a people whose view of the world is fundamentally different from that of the dominant culture who have spent centuries trying to get them to assimilate.

2. Francophone Women

Francophone women in Ontario share with women in some other minority groups the disadvantage of being marginalized for not speaking the tongue of the majority of Ontarians. The passage of Bill 8 (the provincial French Language Services Act) has enabled some franco-ontarians to feel more of a sense of pride and strength in their presence in Ontario while others have spoken of feeling ashamed to be French and hurt by the anti-French backlash created by groups like APEC (Alliance for the Preservation of English in Canada) and the act of certain municipalities declaring themselves English and unilingual. A franco-ontarian interviewee on a recent CBC broadcast said that she felt that choosing to speak her mother tongue in Ontario and to live in a franco-ontarian community was a political act requiring courage and perseverance. This sentiment reflects some of the difficulties faced by all franco-ontarians, not just women. As with other minority groups, when we compound their particular difficulties with being female, we can begin to see the additional strain which they face. The mental health of franco-ontarian women must be considered against the backdrop of francophone politics in Ontario today and the lived reality of franco-ontarian women.

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[71] Dr. E. Connors in The Native Parent in a Changing World, p. 277.

[72] Louise Jilek-Aall in The Native Family: Traditions and Adaptations, p 68.

Dyane Adam, a psychologist at Laurentian University in Sudbury, has devoted a great deal of her time to helping franco-ontarian women. Along with a group of women, she developed a program called "Stress au féminin" (Women and Stress) aimed at helping women take charge of their health and their bodies by identifying the symptoms and sources of stress and developing effective stress management strategies.[73] The program has been used with francophone women in different parts of Ontario and has been highly successful. Adam and her colleagues learned a great deal from the evaluations completed by the women who participated in the program. There are essentially no mental health services specifically for francophone women in Ontario. Their point of entry into the mental health system is usually through their family doctor, who is usually male and anglophone. The women are uncomfortable in these situations and a good rapport fails to be established because of poor communication.

Through her work on the program and her own research, Adam has found that there are a number of factors which put one at risk for mental health problems. The more these factors are present in one's life, the higher the risk of problems. These include: sex (i.e. female), low economic status, being in an abusive relationship, limited language ability, poor education, geographic location (rural or isolated), being alone at home with young children, and a lack of support services in ones mother tongue. Many francophone women in Ontario have all these factors present in their life.

Franco-ontarian women have a higher rate of illiteracy than the Ontario average and are less likely to pursue or complete post-secondary education. (Adam noted that a franco-ontarian women from northern Ontario is 7 times less likely to pursue post-secondary education than a white male from Toronto.) This is not surprising in light of the lack of education services available in French in all parts of Ontario. Franco-ontarians on the whole earn less than their English-speaking counterparts and franco-ontarian women earn less than men. Although more than three-quarters of all francophones live in urban areas, most unilingual francophones live in rural and isolated areas.[74]

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[73] Adam, 1989, p 5.; comments also based on personal interview with Dyane Adam, June 21, 1990.

[74] From an internal document of the Ontario Advisory Council on Women's Issues, The French Language Services Act and the Ontario Advisory Council on Women's Issues.

Lack of mental health services available to women in their mother tongue of French has been noted by a number of sources[75] and is a particularly acute problem for women in the North. Some may argue that franco-ontarians have, for the most part, been assimilated into English culture and the majority understand and can speak English, and can therefore gain access to the English mental health services available. A strong argument must be made, however, for the importance of being able to speak in one's mother tongue when dealing with complex emotional issues, such as those faced by women in abusive relationships, in the post-partum period and at home raising small children.[76]

While it is not expected that violence against women is any more prevalent amongst francophone women than among other women in the province, franco-ontarians face the problem of lack of services available to them in French. In southwestern Ontario, the Réseau des femmes du Sud de l'Ontario has organized and operated a 1-800 distress line (S.O.S. Femmes) for women experiencing violence in their lives. The line was created in response to a need which was identified in consultation with francophone women in this part of the province. Over the two years they have been operating, they have found that they receive almost as many calls from women for issues not related to violence and more related to isolation and need of services. The Réseau has also spawned a group called Le Front commun contre la violence who have organized awareness-raising activities in various parts of southern Ontario, including the touring of a play about violence against women which was performed in a number of elementary schools. In their consultations with women throughout southern Ontario, the Réseau also learned that lack of self esteem and assertiveness was a major issue for francophone women. They have recently been granted federal funding to train women to become facilitators for workshops on self esteem and assertiveness training.

Adam spoke of the need for programs like those being created by the Réseau des femmes, and in particular of the need for self-help programs and networks based on such issues as violence and depression. In Sudbury, a project is under way to set up a centre or clearinghouse for self-help groups for francophone and Native groups. For many franco-ontarian women now in their middle and senior years, the church has provided (or, in some cases, not provided) the spiritual and emotional support that they need. As younger women reject that tradition, they are seeking alternatives such as self-help and peer-support groups to fill that gap which has been left.

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[75] Pageau & Associés, conversation with Dyane Adam.

[76] This issue is discussed in more detail from a clinical perspective in an article entitled "Strategies and risks in psychotherapy with bilingual patients: The phenomenon of language independence" in American Journal of Psychiatry (Marcos and Alpert), Vol 133, No 11, November 1976. In this they note that "... the perception of role, recall, and projection of past experiences - three crucial aspects of the therapeutic process - are affected by the language of the report" (p 1276).

3. Immigrant and Visible Minority Women[77]

> "It (is) more difficult for a woman as an immigrant. I think if she's in her home and not working, and the man is out there, he's socializing, and he's getting all the skills it takes to live in a new place, and the woman is at home, she isn't getting any of those. But she is also getting some of his frustrations, and it's more than the man who was born here."[78]

In 1988, the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees released its report and recommendations based on submissions from groups and individuals from across Canada. The authors noted that "since the factors which create stress for migrants apply particularly strongly to women, policies and programs which address these factors are of even greater importance for women than for men".[79] In the report, women from traditional societies are seen to be at particularly high risk for developing mental health problems as the result of a number of factors. A submission to the Task Force by the Immigrant Women's Group of P.E.I. noted that: ".. we come from societies where men and dogs roam while women and cats remain at home. Unable to communicate fluently, the woman's apartment soon becomes her prison".[80] The group summarized the situation for immigrant women this way:

> "Immigrant women live in situations that are conducive to the development of many psychological fears, anxieties and stress. Some, as newcomers, encounter social confusion and pressure of a fast-paced highly mobile society. Facing language and cultural barriers, they tend to live in their own shells, suffering feelings of isolation, loneliness and despair. Rearing children without extended family support and guidance can be a traumatic and emotionally draining

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[77] It is important to note the distinction between immigrant women and visible minority women. An immigrant woman may or may not be a visible minority woman and, when this is the case, they face not only the problems faced by most immigrant women but the additional burden of living in a predominantly white society with its racist attitudes. A woman who was born and raised in Canada may also be a visible minority woman. She may develop problems which stem specifically from her visible status and not from having had to adjust to a new culture and country. For purposes of this document, this section deals primarily with immigrant women who may or may not also be visible minority women.

Some have used the term "visible minority" to include all those who stand out from a white mainstream, able-bodied white population. This would then include Native people, people with disabilities and the elderly. Because these groups are discussed under separate headings, they are not included in this section of the document.

[78] Quotation from a woman interviewed in the context of report by Lilith Research Consultants for the Ottawa Carleton Immigrant Services Organization, 1985.

[79] After the Door has been Opened, p 76.

[80] op cit.

> experience. Some may suffer from emotional battering as a result of marital discord where partners suppress their anger with silence... Some suffer from nervous apprehension over their teenage children, spouses and other family members when addicted to alcohol or drugs or a deviant lifestyle in search of a new identity."[81]

In contrast with the majority of immigrant men to Canada, two-thirds of immigrant women arrive as family-assisted or family-sponsored immigrants. This entry status, as Christina Lee of the Ontario Women's Directorate has noted, "enforces their dependence on their sponsors, who may be their spouses, for a period of up to ten years, during which time they are not eligible for some of the major subsidized language training, legal aid and social assistance".[82] In addition, they "are much less likely to enter Canada in a category designated to participate in the labour force".[83] Hence, the situation for many women emigrating to Canada is such that they "not only leave what is familiar more reluctantly than men; they must also resettle in surroundings which initially have less to offer them".[84]

This involuntary dependence on their sponsors (be it spouse or other family members) which is sometimes heightened by lack of knowledge of English or French, can have a significant impact on an immigrant woman's mental health. We have already seen the extent to which violence against women can have significant repercussions for women's mental health. Immigrant women are no exception. Accurate data on rates of abuse of women by spouse or other family members is very hard to come by, although Lee notes that "many service providers believe that the proportion may be even higher among this group than among Canadian women" and that "the lack of demand for services may be due to the cultural taboo against discussing domestic conflicts to outsiders".[85] Representatives of a community-based immigrant service organization in Vancouver have noted that "without the traditional safeguards afforded by family networks, men are more apt to 'take out their frustrations' on their wives, frustrations which usually peak when the men fail to find meaningful employment".[86]

Immigrant women are also vulnerable to abuse and exploitation in their work environments. Often with poor or limited language ability, they find themselves in isolated job ghettos doing piece-work in factories or domestic service, situations which put them at much greater risk for feelings of isolation and depression and potentially more serious mental health problems. That sense of alienation is also experienced by many who are unable to find work, as articulated by an immigrant women's organization in P.E.I.:

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[81] P.E.I. Immigrant Women's Group, 1987.

[82] Lee, 1988.

[83] Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988, p 73.

[84] op cit.

[85] op cit.

[86] Submission to the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees from the Orientation Adjustment Services for Immigrants Society of Vancouver, 1988.

> "In attempting to find employment, many of us find that our qualifications are not recognized, stripping us of ego and status. Failure to be self-supporting is perhaps the most demeaning and demoralizing experience one could suffer."[87]

The Canadian Task Force noted two types of educational disadvantage among immigrant women: "Some are extremely highly educated but many more are illiterate. Barred from many jobs, the higher educated are prone to underemployment and the illiterate to dead-end jobs."

In a comprehensive report on the mental health service needs of immigrant women in Ottawa-Carleton, the authors speak about some commonly held beliefs regarding the mental health of new immigrants:

> " ... there is a commonly held belief, dating back to the turn of the century, that immigrants have greater rates of mental illness than native born populations. The basic strategy of most research in this area has been to establish an association between immigrant or foreign born status, and rates of mental illness, usually as revealed in mental hospital admission data. Research in this field spans over half a century, and includes a number of contradictory findings. Studies vary greatly in how they define mental illness and ethnicity; in the selection and sizes of samples and in the methods of analysis."[88]

The authors go on to question that commonly held belief and the degree to which it reflects racist attitudes and perpetuates racist sentiments among Canadians. There is a growing body of literature and a breadth of personal anecdotes to indicate that diagnosis of an immigrant's mental illness is sometimes the result of mis-communication due to language and cultural barriers on the part of health and social service workers. Christina Lee has noted that the most often prescribed drugs for immigrant women are major tranquillizers, followed by anti-depressants and anti-psychotics.[89] This tendency towards heavy prescribing to immigrant women is often the result of an inability of a health care provider to know what else to do:

> "The treatment of mental health problems requires verbal communication and self-disclosure. Most immigrant and visible minority women have difficulties

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[87] P.E.I. Immigrant Women's Group, 1987.

[88] Lilith Research Consultants, 1985, Appendices, p 2.

[89] Lee (op cit) citing Brown and Harris, 1978.

> expressing emotional problems in a foreign language. Somatization[90] in terms of body pain is often used."[91]

Also important with respect to helping immigrant women with mental health problems is consideration of the fact that the notion of therapy or of any type of personal disclosure of problems is a western phenomenon which is alien to many cultures. It is vital that this be kept in mind in the creation of any mental health programs for immigrant women.

Another commonly held belief which the authors of the Ottawa-Carleton study challenge is that of the image of immigrant women as dependent, subservient, and more traditional than other Canadian women, an image which was prevalent in a review of the literature. While this may be true of some immigrant women, it is also true of some Canadian women, and generalizations of this nature are discouraged by the authors. They found that the literature also revealed that what the real problems were for immigrant women when they were able to identify them themselves and not always have them identified by others were "primarily those of being women in an industrialized urban setting, at times aggravated for many women by virtue of not speaking English and/or being members of visible minorities in a racially stratified society".[92]

A study of minority ethnic group access to health and social services in Ottawa-Carleton found that "mental health services are the most pressing of all needs experienced by minority ethnic group members".[93] The key barriers to better access to service which were identified included lack of information and related documentation (e.g forms) in languages other than English, lack of personnel who speak languages other than English, cultural appropriateness of services and the lack of appropriate referral agenciés for immigrant aid workers.[94]

4. Rural and Isolated Women

Under this heading we include women who live in remote and isolated areas as well as farm women who may or may not be in isolated areas.

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[90] Somatization: "1.the production of physiological dysfunction often resulting in irreversible structural changes by the exaggeration and persistence of an emotional state; 2. the expression of psychological conflict through somatic symptoms" (Webster's Third New International Dictionary).

[91] Lee, op cit.

[92] Lilith Research Consultants, 1985, p 14 (Appendices).

[93] Bergin, 1988, p 6.

[94] op cit, p 4,5.

It has been noted that some farm women face not just a double workload (i.e. those working in the home and on the farm) but a triple workload (in the home and on and off the farm).[95] A study conducted by Women for the Survival of Agriculture (in Eastern Ontario) in 1985 found that women tended to undervalue their contribution to the family farm and are "slow to commend themselves for their...input". We have noted above the psychological toll on women who maintain a double workload. This can only be magnified for some farm women, and constitutes a risk factor for mental health problems. The situation is compounded by the fact that net farm income has declined over the years in Ontario creating a strain for farm women and their families. The structure of the family farm, supported by a system which has women subsidizing the total family income, is such that to the outside world, farm women receive very little recognition for their work[96], a factor which has implications for a woman's sense of self-worth and self-esteem.

The WSA study also cited the lack of support services for farm women as a major problem. In particular, childcare services and services for battered women were highlighted.

> "Domestic violence in rural areas is believed to be as prevalent as in urban areas. Some would say more so, due to the isolation, the economic dependency of farm women, the lack of anonymity and the traditional values of the community, which often prevent a farm woman from seeking help."[97]

In a study of stress and farm women conducted in western Ontario (Ireland, 1983) women listed the main source of stress as a lack of profit, followed by other financial concerns including no money for holidays and no leisure time. Stress was most commonly manifested in the form of mental fatigue, followed by frustration, irritability, indecisiveness and sleeplessness. It is noteworthy that spouses were seen as a source of support in over 50% of cases responding. The least satisfying means of support for those experiencing difficulties was reported to be professionals. Fifty-eight per cent of women who went to professionals were prescribed drugs and less than half of that group received counselling along with the drugs.[98]

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[95] Women for the Survival of Agriculture, 1985, p 12.

[96] The WSA study notes that it is common for a sales person to greet a farm women with the line "Where's the boss?". As testimony to the strength of these women, we are also told that the standard reply is "You're talking to her!" (p 44)

[97] ibid, p 34.

[98] A noteworthy aspect of this report is that it did not mention the issue of wife abuse, in contrast with the report done by Women for the Survival of Agriculture which gave considerable attention to the issue. Admittedly, the latter report is more recent, but the fact that there was no mention at all in the Ireland report could be seen as a reflection of how difficult it is for farm women to talk about this issue and that what we do know about the situation in Ontario (thanks to the courage of WSA in bringing the issue out in the open in a public document) may only represent the tip of the iceberg.

University of Toronto gerontologist Elizabeth Cape has studied older women in rural areas and was surprised to find the lack of social support available to them and the degree to which women's roles are so sharply defined in rural areas:

> " The village of "Dairyville" in the Ontario township I have studied is a good example. At a recent meeting of the men's service club, one of the township's "new" residents (six years) suggested that the club sponsor a "wheels-to-meals" program, but this was voted down and the members went back to discussing ways and means of raising funds to pave a parking lot... Women have no voice in these councils, nor do they seek admission. In Dairyville, women are in charge of the bake sales and Christmas bazaars, and a women's auxiliary prepares and serves the dinners which precede service club meetings. When village females grow too old, and/or lose the desire to participate in these culinary efforts, there is little else of a social nature to take their place."[99]

Mental health concerns for women in isolated and remote areas were the subject of a project spearheaded by the Northwestern Ontario Women's Health Education Project of Thunder Bay. During the winter of 1983, the group delivered "Cabin Fever" workshops to women in 15 regional communities in northwestern Ontario. Women in isolated areas share some concerns with farm women in Ontario but also have their own set of unique issues. Cabin fever is described in this way by the group:

> " Cabin fever is characterized by depression and irritability, and generally occurs during the confinement and isolation of the long winter months in the North. While most women will express positive feelings about living in small isolated communities, the positive elements are often associated with benefits for their husbands and children."[100]

The feelings the women in the workshop described included: frustrated, resentful, guilty, lonely, apathetic, unmotivated, lethargic, bored, depressed, isolated, cut off, confined physically and emotionally, suffocated, anxious, hostile, helpless, trapped, left out, angry, harassed, dissatisfied, overwhelmed, victimized, restrained, cramped, unsociable, frightened, tense, sad, powerless, and not belonging.

The causes of their feelings include cold weather, long winters, unemployment, being too far from facilities, staying at home, being labelled housewife, isolation, lack of opportunities, lack of work, shift work, transiency, living away from family and friends, lack of childcare, transportation, lack of places to go, lack of facilities/resources, lack of community programs, limited shopping, distance to cities, prices in the north, lifestyle controlled by husband's job, envious of husband's leisure activities/freedom and lack of living space.

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[99] Cape, 1982.

[100] McInnis, 1986, p 4.

Pat McInnis of the Women's Crisis House in Sioux Lookout describes what she believes to be the source of the problem, an observation which could be applied to most women experiencing emotional and psychological difficulties:

> " If we continue to deal with women individually, we fail to deal with the major factor in their imprisonment - ... the perception of each woman that the problem is hers alone. Because she sees it as hers, she feels responsible and sees herself as to blame. Because she sees it as hers alone, she is prevented from seeing the commonality of women's problems and the sources in the society we live in. Because she feels alone and to blame, she has a limited sense of control and a limited ability to act. She remains depressed and passive. If she could rise above the individual perspective to see the limitations placed on her from without, if she could begin to get validated for her perceptions and support from other women, she would be mobilized to experience personal control and the ability to take action."[101]

While mental health issues for rural and isolated women have many commonalities, services and programs must be designed in a way which considers the unique aspects of their region.

5. Women With Disabilities

A discussion of women with disabilities includes those with psychiatric or emotional problems, the developmentally disabled, the deaf or hard-of-hearing, the blind or low-visioned, those with mobility difficulties and those with invisible disabilities, including epilepsy, diabetes and learning disorders.

As a minority, and among the poorest of all women in Ontario[102], women with disabilities experience tremendous psychological and emotional strain and significant barriers to obtaining appropriate mental health services.

At the inaugural meeting of DAWN (DisAbled Women's Network) Canada, low self image was ranked as the most pressing concern. Few girls with disabilities grow up with positive role models, living as we all do in a culture which emphasizes physical attractiveness in women. As a DAWN report on self-image indicates:

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[101] ibid, p 5.

[102] Ross and Shillington, 1989, p 28.

> "A strong self-image is essential to gaining access to the world of work, to developing strong, egalitarian, intimate relationships, to effective parenting, and to resisting the violence that pervades our society."[103]

The above author has also noted that family breakdown often occurs as the result of having to cope with the demands of a child with disabilities. "For most women with disabilities", she adds, "psychological and verbal abuse are a fact of life." Mothers of disabled children whose husbands abandon them often experience more poverty, social isolation and depression.

> " When a child feels resented and comes to understand that she is in some way less than perfect, she may come to see herself as unlovable, worthless and potentially dispensable. All children have a fear of being abandoned. For a child born with severe disabilities, the fear of being abandoned or sent away to an institution may be very real."[104]

Society tends to stereotype people with disabilities, using negatively charged language like "victims of", "afflicted with" or "confined to a wheelchair". Language can be a powerful oppressor and label the disabled as passive and vulnerable. Many women with disabilities have spoken about the lack of sensitivity from caregivers, including health care professionals, particularly with reference to such issues as sexuality, addictions, and abuse.[105] The lack of accessibility which women with disabilities face when trying to gain entrance to services related to these issues reflects the unwelcoming message conveyed to the disabled and reinforces a sense of alienation and isolation. Pat Danforth, who became a paraplegic at 21, writes of her psychiatrist's response to her concerns about birth control:

> "... no one volunteered information on this subject. My psychiatrist (a specialist in rehabilitation medicine) responded to my tentative questions on birth control by saying that it was time I had my own general practitioner, clearly giving me the message that sex and related matters were outside the realm of "rehabilitation"."

The extent of violence against women with disabilities is emerging as a major issue for the disabled women's movement. In a small study conducted by DAWN Canada in 1988, 40% of women who had responded had been raped, abused or assaulted, 64% had been verbally abused and it was found that women with multiple disabilities were more likely to be abused and by more people.[106],[107] As victims of violence, some women with disabilities maintain that they experience worse treatment than able-bodied women from the medical profession. One respondent to the DAWN study commented:

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[103] Ridington, 1989, p 1.

[104] ibid, p 1.

[105] Ridington, 1989. Danforth, 1985.

> " Symptoms that indicate sexual abuse and incest in able-bodied women are overlooked by many physicians. Such symptoms are even more likely to be overlooked in women who are not seen as women but as a "case" of multiple sclerosis or cerebral palsy."[108]

One study recently carried out at the Queen Street Mental Health Centre in Toronto found a disturbingly high incidence of violence against women with psychiatric disabilities at the centre.

It has been argued by many authors that women with disabilities experience more discrimination than men with disabilities.[109] Women with disabilities are disadvantaged in the areas of employment, education, vocational services, health care and parenting activities. Danforth has noted that "the women's movement does not address my disability-related concerns while the disabled person's movement does little more than provide token support to women with disabilities. As a result of this frustration felt by many women with disabilities, DAWN Toronto circulated a manifesto of sorts to women's groups in 1987 arguing that they were being discriminated against by the women's movement and outlined the ways in which things would have to change before women with disabilities felt a part of the movement. Some saw this as "fascism", others as "a tremendous act of courage".[110] The end result of the act was that more and more women's organizations and social service agencies have improved accessibility to women with disabilities and budget items for accessibility renovations are seen more frequently on funding applications to the Ontario government. Nonetheless, there is still considerable room for improvement.

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[106] Ridington, 1989.

[107] Similar research with a larger sample size is under way at the University of Alberta in Edmonton (principal investigator: Dick Sobsey). The researchers have come up with strikingly similar findings to the DAWN study.

[108] Ridington, 1989.

[109] Several of these studies are cited in Griffith-Kenney, 1986, p 240.

[110] Based on discussions heard at meetings of the Toronto Women's Health Network at the time the flyer was circulated. The Network now meets in wheelchair accessible space.

6. Older Women

> "It's very debilitating to think of ourselves as a burden to others when we are sick or needy. We have, however, as women, been systematically expected to serve and nurture others, to sacrifice the self. Many women still impair their physical and mental health by trying to meet this insidious demand. In many ways, old age gives us the chance to refuse the role of servant at the ready of others. In 1949, Simone de Beauvoir wrote that women finally achieve independence in their old age and by then it's too late. I think it no longer has to be too late."[111]

The proportion of Ontario's population over 65 is on a steady increase and women make up the majority of that group, outliving men by an average of 7 years in this country. Researchers have been inconsistent about stating when "being old" begins; some have included women as young as 50, since it is believed that the concerns of women in this group have more in common with their older counterparts than with younger women.

In a round table discussion on women and aging sponsored by the Seniors Secretariat of Health and Welfare Canada and Status of Women Canada in 1988, the key issues were summarized this way:

> "A cycle of lifelong poverty for many women begins when they become single parents; for others, poverty begins between the ages of 45 and 65 when they find themselves without access to income security programs or employment. Lack of occupational ties and decreasing numbers of social ties as women grow older and less mobile create problems of social isolation. Attempts to cope with the resulting depression and other physiological and psychological symptoms sometimes lead to "overmedicalization" and to drug and alcohol dependencies."[112]

Given that very brief summary, and what we know about the determinants of mental health, it becomes clear why older women in Canadian society are at particularly high risk for mental health problems. As women reach their older years, so many high risk factors coincide to make this a time when women may begin to develop mental health problems or when previous mental health problems may become aggravated: increasing poverty, changing identity in the family, widowhood, lack of opportunity in the employment market, housing problems, coping with physical health problems and in particular, chronic pain. The likelihood of many of these predisposing factors being present increases if, in addition to being old, she is a member of a minority group.

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[111] Levine, 1985.

[112] Seniors Secretariat of Health and Welfare Canada and Status of Women Canada, 1988.

In Canada, we institutionalize our elderly at a rate almost 80% higher than the United States and 90% higher than Britain. More specifically, almost 10% of Canada's population over 65 are in chronic care hospitals or nursing homes.[113] As noted earlier, women outlive men in Canada by roughly seven years; hence the majority of those institutionalized are women. Organizations such as Concerned Friends of Ontario Citizens in Care Facilities have done a considerable public service in making citizens aware of the sometimes inhumane conditions in such institutions and have actively lobbied the Ontario government for change.

As a woman ages, she must slowly realize that we live with a double standard of aging in western society; while men tend to gain respect, prestige and status with age, women are seen as less valuable, having lost their ability to reproduce, and losing their youthful looks so highly prized in North American society. Montréal psychologist Barbara Wainrib asks:

> " How does the North American world reflect an older woman's image back to her? Researchers have shown us that older women in our society are seen not only as less sexually attractive, but as "poor", "dumb" and "ugly". ...Psychological researcher Lillian Troll found that not only are women seen that way by our society, but the psychosocial image is so effective that many women whom she tested have internalized it. Even women who might have grown older, feeling internally strong and competent and attractive, reported that they too felt "poor", "dumb" and "ugly". Her research indicated as well that when middle-aged women were shown pictures of older women, they had absorbed the norms too and said "Oh, these women are ugly!"[114]

It should be noted, however, that in certain minority cultures, such as the Native culture and in certain non-Western societies, to be an older woman is to be respected and valued, to be consulted for her wisdom, rather than marginalized.

In a key informants' study of women in their middle years (defined for this purpose as 45 to 70) conducted by Women's College Hospital in Toronto, depression and isolation were identified by 64% of those interviewed as a concern for women in this age group. The factors identified which contribute to the depression and isolation included inadequate income and low pay, abuse from a spouse, chronic pain (arthritis and rheumatism in particular) lack of recognition for their role as homemakers and, for immigrant women, a lack of health and social services in their language and a lack of services which were sensitive to cultural differences.[115]

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[113] Rachlis and Kushner, 1989, pp 25 & 154.

[114] Wainrib, Barbara, 1989, p 61.

[115] Ford, 1989.

Mavis Wilson, when she was Ontario's Minister Responsible for Senior Citizens, noted in a conference on women and aging that "... a large majority of women over 60 years of age are responsible for the care of elderly family members age 85 and up." She added that " ... in future years, women will spend more time caring for elderly family members than children". Again, this role is an undervalued one often taken for granted by family members and society.

The stereotype of women in their middle years is one of being a depressed or emotionally unstable menopausal woman.[116] Many (including some physicians) believe that depression in women in their middle years is caused by the hormonal changes of menopause.[117] Although some women do experience depression at the same time as menopause, there is not strong support from the medical literature to indicate that it is the menopause itself that causes the depression. Cobb explains why the myth prevails:

> " Despite the fact that menopausal women are less likely to suffer from clinically diagnosed depression than are much younger women (particularly mothers of young children) depression continues to be a bugaboo. Not only are women frightened about being depressed, they are ashamed to admit that they are depressed... There is also the stigma of depression; depressed women have traditionally been treated as if they were personally responsible for their condition."[118]

The old psychiatric diagnostic term which was used for depression at menopause was "involutional melancholia" which means "inward-turning sadness". Whether there truly is a biochemical explanation for this depression, there are certainly good reasons for experiencing an inward-turning sadness: some women experience a certain degree of grief at the loss of their ability to reproduce (others welcome the freedom from menstrual concerns); some women experience sadness at the loss of children from the home which frequently coincides with these years in a woman's life; a re-adjustment to new roles resulting from a possible return to the labour force, their own retirement or a partner's retirement can be unsettling; the reality of women's economic insecurity sets in for some women at around this time; and women who experience hot flashes and considerable sleep disturbance as a result of the hormonal changes of menopause may become depressed simply from lack of sleep.

As women age, they are more likely to be inappropriately prescribed drugs and to use over-the-counter drugs. In a Canadian study conducted in 1985, nearly a quarter (23%) of women 65 and over reported sleeping pill use and 14% in this age group used tranquillizers.[119] The Canadian Medical Association recognizes seniors as a special risk group in its new guidebook to drugs and lists special precautions for this group under specific drug classifications. Older women use twice as many prescription drugs and more non-prescription drugs than older men and physicians are twice as likely to prescribe tranquillizers to women as to men.[120]

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[116] This stereotype has pervaded all forms of media until quite recently as women have begun to openly object to it. One of its most blatant forms in the 1970s was in advertising for drugs for women in this age group, frequently showing women as depressed, angry, frantic or exasperated. For examples of this see Ford, A.R., "In poor health: Women in pharmaceutical advertising", Healthsharing, Fall, 1987.

[117] McKinlay & McKinlay, 1989, p 1.

[118] Cobb, 1988, p 57.

Older women are at risk of abuse just as are younger women, but additionally so by their own children. Women who experience what has come to be known as "elder abuse" (or, in the popular media, "granny bashing") are typically older than 80 years of age, often frail or suffering and dependent on their caregiver for their emotional and physical needs. Abuse can take the form of being assaulted, beaten, pinched or mishandled but the most common form of abuse is neglect and emotional deprivation.[121] Researchers at the Family Research Laboratory at the University of New Hampshire warn that it is not only children who are abusing. In a study which they conducted in 1987, only 23% of the victims had been abused by their children, while 58% had been abused by their spouses. One of the researchers noted that "since spouse abuse of all ages has generally been ignored until recently, the actual rate may be even higher".[122]

Observers from other countries (in particular, some of the Scandinavian countries) have remarked at the inhumane way in which our elders are treated in Canada. Madeleine Honeyman of the Alzheimers Association of Canada asks:

> " Why is old somehow synonymous with disease, worthlessness and incompetence? It was not always so. Until the arbitrary retirement age was set, old equalled wise. In Ontario, part of this problem may arise because OHIP does not pay a fee for "listening". Often the old are hard to hear unless one has a "third ear"".[123]

Honeyman's comment reflects not only a lack of emotional support from health professionals but from the community at large. Gerontologist Elizabeth Cape, in a study of elderly women from a rural area of southern Ontario, was surprised to find "the lack of fit between their social and health needs and the kinds of care offered by neighbours and kinfolk". She also found "loneliness to be endemic, even among women who had known one another since grade school".[124] Solutions to this type of loneliness and alienation have been found in other countries. In Sweden, for example, homes for senior citizens are placed in close proximity to child care centres and children have an integral part in the lives of the elderly. It is this type of structural change which can greatly improve the quality of life and the mental health of older women.

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[119] Andrews & Rootman, 1990, p 28.

[120] Cooperstock & Hill, 1982.

[121] Griffith-Kenney, 1986, p 381.

[122] A report of this study appeared in the Ottawa Citizen, March 23, 1987. Authors of the study were Karl Pillemer and David Finkelhor.

[123] From the proceedings of the conference "Women in an Aging Society", Halifax, Nova Scotia, October 20, 1988.

7. Lesbian Women

In a review of health issues for lesbian women, Toronto psychologist Rosemary Barnes points out that

> " most lesbian health concerns have to do with the psychological hazards of living in a world which is at best unresponsive, at worst hostile to the experiences of women loving women".[125]

Critical to any discussion of mental health issues for lesbian women is an understanding of the fact that until 1973, homosexuality was listed as a form of psychosis in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (as noted previously, this is the most widely used reference of most mental health professionals). In other words, one could be institutionalized for being gay. But as Toronto psychologist and anti-psychiatry activist Bonnie Burstow has noted, removing it from the DSM has not changed that much - "you can still find people who are being psychiatrized and locked up for being gay right now".[126] This inclusion of homosexuality in the DSM, thereby, making homosexuality a mental disorder, is an important historical fact not only because of how it reflects the degree to which our society is homophobic[127], but because it represents a power which the psychiatric profession has had over gays and lesbians and the problems which they are up against when seeking help for mental health problems. Since its exclusion from the DSM, gay activists have lobbied against the inclusion in 1974 of a new diagnostic category called "sexual orientation disturbance", renamed in 1980 "homosexual conflict disorder".

The last issue of *Phoenix Rising* (a Toronto-based magazine whose subtitle is "the view of the psychiatrized", and has been produced by ex-psychiatric patients until this year for the last ten years) which came out in July 1990 is devoted to issues for gays and lesbians.

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[124] Cape, 1982.

[125] Barnes, 1985, p 175.

[126] From a radio interview with Bonnie Burstow on CKLN radio in Toronto, December 19, 1989.

[127] Homophobia is defined in the last issue of Phoenix Rising as "the irrational fear of homosexuality".

For a clear understanding of the harm done to lesbians by the psychiatric profession, the magazine is worth noting. It includes many personal testimonies of psychiatrists' attempts to "straighten out" gay clients, to get lesbian women to "find themselves a man", attempts to numb their memories through electroconvulsive therapy (ECT) "treatments" and extensive prescribing of drugs, both in and outside of institutions - and most of this since 1973.

It is not surprising, as Barnes notes, that finding a supportive and properly informed treatment setting can be difficult for lesbians. For this reason, lesbian women in different communities are increasingly organizing self-help groups focusing on such issues as substance abuse problems, dealing with incest, and parenting in a heterosexual world.

In a workshop on mental health issues for lesbian women at the 1989 Women and Mental Health conference in Banff, the workshop leaders summarized some of the mental health challenges lesbians face:

- confronting their own homophobia, internalized through years of experiencing it themselves
- confronting their own fears about their sexuality
- feeling they have no choice about remaining in the closet (i.e. not revealing their homosexuality to others)
- dealing with their two "families" - the one into which they were born and their circle of friends
- concern about protection because of increased violence faced by gays and lesbians[128]
- confronting drugs, alcohol and violence in lesbian households.

Additional concerns include the acute isolation of lesbian women in small or closed communities, custody problems faced by lesbians with children, and the lack of "family" benefits available to employed lesbians' partners.

Because many suffer the on-going strain of societal homophobia (feeling different stresses and pressures based on whether they are "out" or still "closeted"), it is not surprising that suicide attempts appear to be more common amongst lesbians and roughly 20 to 40% of lesbians have drug and alcohol problems.[129] Toronto writer Frances Rooney writes of the pressure under which lesbians constantly live:

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[128] In Toronto, the 519 Church Street Community Centre recently set up a "Gaybashing Hotline" as the result of a significant number of attacks on gays and lesbians in the city. Callers can call without identifying themselves to report an incident and to get advice and counselling.

[129] Barnes, 1985, p 175-176.

"We are members of a group who identify themselves to each other, always with fear, through an elaborate system of codes. Those who don't know the codes or consider exposure too dangerous that they dare not ever connect with their own kind, may spend their entire lives hiding - from the world and from themselves. The isolation is devastating."[130]

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[130] Rooney, 1982, p 20.

Women and Mental Illness: Disorders or Coping Mechanisms?

Paltiel has noted in her extensive examination of the literature on women and mental health[131], that although there is a considerable body of literature indicating that women suffer more mental illness than men, data on a number of disorders is not conclusive. A prevalence in women has been firmly established in the areas of major depressive episodes, agoraphobia and simple phobia. Panic disorder and obsessive compulsive disorder appear to be more common in women. Some studies have found schizophrenia to be more common in women, others more common in men. Men show a clear predominance in alcoholism, drug dependence and anti-social personality.[132]

While biological theories exist to explain most of the disorders common to women, most feminists working in the field have written that all mental illness in women must be considered in the context of their life situations and social circumstances. American mental health activist Judi Chamberlin put it most succinctly "It's silly to be looking at people's brains instead of looking at people's lives".[133] As Canadian author Angela Browne notes "Even its biggest proponents admit that there is still no reliable laboratory or diagnostic test for schizophrenia or manic depression in an individual."[134] Literature reviewed in the course of preparing this report would indicate that use of the biomedical model for explaining certain mental illnesses is increasingly being called into question.

Historically, an intriguing array of theories have existed to explain mental illness in women. In the 19th century, for example, one commonly accepted theory was that women's mental illness was the result of problems based in the uterus[135] or ovaries. It was not uncommon for gynecologists to perform operations on these organs to "cure" mental disorders. A theory more popular in the late 19th century was that women suffered from a particular nervous disorder, "neurasthenia", and although it was not felt to be particular to women, its treatment for women was unique. A popular "cure" was known as "the rest cure". Charlotte Perkins Gilman, an American feminist and author, was diagnosed as having neurasthenia and prescribed "the rest cure" towards the turn of the century. She wrote of this experience both in her autobiography and in a now well-known fictional portrayal, *The Yellow Wallpaper*. In her autobiography, she writes that following "the rest cure", which showed no marked improvement in her condition, the doctor prescribed the following:

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[131] "Women and mental health: A post-Nairobi perspective", 1987.

[132] op cit.

[133] Shapiro, 1984.

[134] Browne, 1990, p 52.

[135] Many view it as no coincidence that the words hysteria and uterus are of the same root, hence the term hysterectomy to describe removal of the uterus.

> "Live as domestic a life as possible. Have your child with you all the time" [Be it remarked that if I did but dress the baby it left me shaking and crying - certainly far from a healthy companionship for her, to say nothing of the effect on me.] "Lie down an hour after each meal. Have but two hours of intellectual life a day. And never touch pen, brush or pencil as long as you live."[136]

The example of Charlotte Perkins Gilman is only one of many which exist to describe the way in which psychiatry can "... take somebody who doesn't fit in and transform her not fitting in into an illness".[137]

In the following section, mental health problems and mental disorders for women are identified[138]. We might do well to keep in mind the advice of Montréal psychologist Barbara Wainrib to her colleagues in the mental health professions:

> " We must work ... hard to undo that stereotype in our therapeutic and diagnostic modes, as well as our social action modes, so that before we label someone "disordered", we know that we've done whatever we can to change the disordered reality of that woman's life."[139]

1. Alcohol and Substance Abuse

Much has been speculated on and written about the reasons for which women drink. Before considering any reasons, a discussion of women and alcohol abuse must be seen against the backdrop of the double standard about drinking in our society. In short, it is socially acceptable for women to drink, but it is clearly socially unacceptable for a woman to be intoxicated. It would appear that more shame is attached to being a female alcoholic. She is thought to be "weak-willed, promiscuous, sexually aggressive, despite data that indicate the reverse".[140] In contrast, the intoxicated male is "treated with indifference, perceived as amusing or pitied for his drunkenness".[141] One American sociologist maintains that historically, "...the taboo against female drinking was one way in which American men symbolized their higher status (relative to women)"[142], a notion which also served to legitimate and in fact glorify male drinking. It is difficult to assess the degree to which that taboo might persist today. It was noteworthy that in a workshop on women and alcohol at the Canadian Mental Health Association's 1989 conference on women and mental health, when participants were asked to describe the female alcoholic, they tended to use terms which were far more derogatory than those used to describe male alcoholics.

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[136] cited in Geller, 1985, p. 1060.

[137] Shapiro quoting Judi Chamberlin, 1984.

[138] Note that this is not a comprehensive discussion or listing of women's mental health problems and mental disorders. It is a partial listing of those issues which either have unique ramifications for women or which are found more commonly in women.

[139] Wainrib, 1989, p 67.

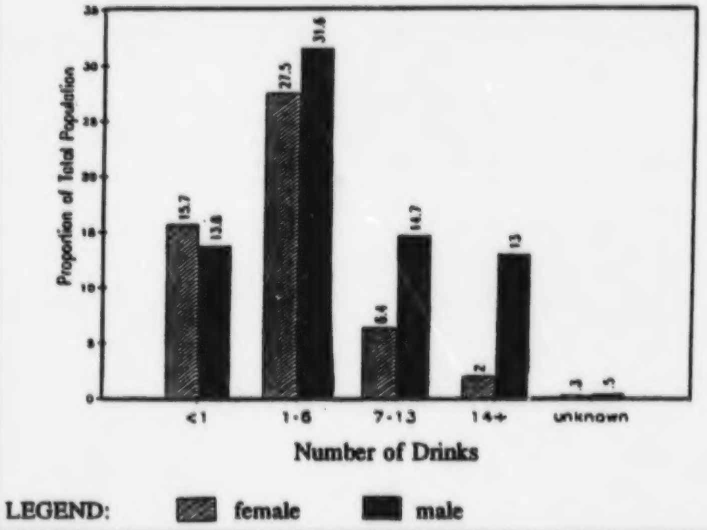
[140] Blume, 1986, p 1467.

[141] Lester, 1982, p 452.

Female drinking patterns have changed over the years and heavy drinkers now appear to be women in their 20s and 30s.[143] Accurate statistics on female rates of alcohol consumption are difficult to come by. Nonetheless, most literature on women and alcohol concludes that female alcohol consumption rates are generally lower than those of men. It must be kept in mind, however, that any data gathered are based on reported cases and some would claim that women are more "closeted" than men about their drinking. Because women report drinking-related problems less frequently than men does not necessarily mean that they drink less than men; hence any data should be viewed with caution. The manner in which the alcohol problem is measured (e.g admissions to detox centres, self-reporting, reporting from family doctors, etc) should also be evaluated when considering such data. (See Tables 1, 2 & 3 for some Canadian data on female alcohol consumption.)

TABLE 1

WEEKLY CONSUMPTION OF ALCOHOL
BY CURRENT DRINKERS CANADIAN POPULATION, 1985



Regardless of whether female alcohol consumption rates may be as high as those of men, treatment programs specific to women's needs in Ontario do not compare with those available for men. In Toronto, for example, where there are over 100 beds for men in detox centres across the city, only 8 such beds are available for women and, until this year[144], no women-only detox centres existed in the city. In smaller centres and more notably in the north, women often have to travel out of their communities for detox and treatment. One can only speculate on the extent to which this is a disincentive for women seeking help. Another disincentive is the lack of child care facilities in both residential and day treatment centres, a problem not unique to Ontario.

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[142] Morrissey, 1986, p 67.

[143] Hollobon, 1987.

The lack of services for women is a reflection not only of a still existing societal taboo against female drinking but confusion about the unique needs of the female alcoholic. Although not universally the case, women usually prefer women-only treatment facilities and appear to do better in such settings. In co-ed centres, the needs of women are often subordinated to those of men, and women who often fear for their own physical safety. An assumption still exists on the part of some in the addictions field that when it comes to treatment, what is good for men is good for women. But women have long maintained that many of the issues which lead them to drink (early histories of sexual abuse by men, difficulties related to their marriage, a discovery of their lesbian sexuality) are not ones which they want to try and work out in the presence of men. The success of places such as Amethyst Women's Addiction Centre in Ottawa, Canada's first residential treatment centre for women, attests to the importance of women-only settings.

Different theories and models for treatment exist, and there is considerable and on-going debate in the addictions field as to what treatment model best applies to women. Treatment models are rooted in an interpretation of what alcoholism is. In the alcoholism field, the debate centres on the disease model (alcoholism is a disease with biological and genetic origins which must be treated as any other disease) and the public health or social model (the social conditions in which we live lead some to drink and treatment must be aimed at changing those conditions as much as possible). In spite of their differences, the two models agree on the tremendous need for support. In an interview with Nancy Huneault, a co-founder of Amethyst Women's Addiction Centre and long active in the field of women and addictions, she commented that in working with women and addictions, "nothing on earth is more important to mental health as what it means to be a friend and how to make and keep friends". She highlighted this as one of the cornerstones of her own personal philosophy about treatment that she has carried with her over the years.

As a result of the women's movement's involvement in the issue of substance abuse, more research is being done on the relationship between earlier histories of sexual abuse and the tendency to drink as adults. Cathy Mayhew of Alberta noted in her workshop on women and alcoholism at the Women and Mental Health conference in Banff that "women who are alcoholic are more likely to have experienced sexual, physical or emotional abuse than their non-alcoholic counterparts and are twice as likely to have been victims of incest or rape." She adds that ".. the abuse in alcoholic women's past will often have been of a longer duration, involved a greater number of perpetrators, and resulted in unsuccessful efforts to disclose".

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[144] In March of this year, Health Minister Elinor Caplan announced that Doctor's Hospital would be granted funding to establish a 20-bed, women-only detox centre.

TABLE 2

ADULT ALCOHOL AND DRUG USE BY SEX, ONTARIO, SELECTED YEARS, 1976 TO 1984

Year	Sleeping Pills	Stimulants	Tranquilizers	Marijuana	Cocaine	Alcohol
			%			
1984: Female	9.9	2.6	12.3	7.1	1.9	82.1
Male	4.6	2.4	6.1	15.6	4.8	86.4
TOTAL	7.3	2.5	9.3	11.2	3.3	84.2
1982: Female	8.1	3.1	9.4	4.1	---	72.5
Male	4.3	3.5	6.0	12.3	---	80.4
TOTAL	6.2	3.3	7.7	8.2	---	76.4
1977: Female	10.1	1.8	17.3	5.8	---	76.5
Male	6.9	1.6	9.4	11.6	---	87.1
TOTAL	8.5	1.7	13.2	8.6	---	82.1
1976: Female	11.1	0.6	19.3	2.3	---	75.2
Male	8.1	0.8	8.2	8.2	---	85.7
TOTAL	8.6	0.7	13.7	5.8	---	80.5

Source: Addiction Research Foundation, Statistics on Alcohol and Drug Use in Canada and Other Countries, 1982 and 1984.
Notes:1) Data based on Gallup household surveys with sample sizes of 1,545 in 1976, 1,772 in 1977, 1,040 in 1982 and 1,051 in 1984. Users are defined as anyone who has used alcohol or the drugs within the previous twelve months, with the exception that for alcohol use in 1982 and 1984, users are defined as anyone who has every used alcohol. Number of users based on self-reporting is likely to be underestimates. These figures provide a general view of the minimum level of use.
2) From 1982 on, figures have been adjusted to exclude "not stated" and "don't know" responses.

In a controlled study conducted in California in 1986, where a group of recovering female alcoholics were matched with non-alcoholic women, the rates of abuse were noticeably higher in the recovering alcoholic group: 74% - sexual abuse (versus 50% in the control group), 52% physical abuse (versus 34%), and 72% emotional abuse (versus 44%).[145] It was also found that the extent of abuse experienced in the recovering alcoholic group differed in quantity, quality and extent. The author points to the significant impact of these experiences on a sense of trust and intimacy in the female alcoholic.

While accurate data on consumption rates in women is difficult to obtain, a good deal is known about the biological differences between male and female reactions to alcohol, and the differences are considerable. In very general terms, the harmful effects of alcohol appear to be worse for women than for men.[146] In addition to specific effects on their reproductive systems, women metabolize alcohol differently than men and "liver damage in women occurs after alcohol is consumed in smaller quantities or for shorter periods than are required for damage for men". This may be due to "higher blood concentrations in women, resulting from a smaller volume of distribution".[147]

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[145] Covington, 1986, p 37.

Another very harmful effect of alcohol in women is that of **Fetal Alcohol Syndrome**. Because of alcohol's ability to cross the placenta during gestational development, children born to women who consumed a significant amount of alcohol at key points in their pregnancy are at very high risk for developing a wide range of problems. Although only firmly established in the medical community as recently as 1970, an awareness of a possible link goes back as far as the Greek and Roman empires. The Carthaginians and Spartans, for example, forbade couples to drink alcohol on their wedding night because they believed that a malformed child might be conceived. The link between alcohol consumption and fetal abnormalities is now a considerable area of study in addictions research.

The most commonly found characteristics of Fetal Alcohol Syndrome are a failure to attain normal length and weight, an unusually small head circumference and foreshortened eyelid openings. Mental deficiency, head and facial deformities, joint and limb abnormalities, cardiac defects and central nervous system impairments are also found in a significant number of cases. Most of these effects remain with the offspring for life.

Of other substances included in the term "substance abuse", women exceed men in their consumption of both prescription and over-the-counter medication.[148]

A sizable body of literature and data shows that a significant percentage of the Canadian population receive some type of prescription for mood-modifying drugs.[149] Of those prescriptions, women receive twice as many as men for benzodiazepines[150] and two to three times as many as men for anti-depressants[151].[152] It has also been established that they are most frequently prescribed to elderly women and to women caring for pre-school children.[153]

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[146] Schenker and Speeg, 1990; p. 129.

[147] ibid, p 128.

[148] The term sometimes includes cigarette smoking as well, but for purposes of this report, tobacco will not be examined.

[149] Various studies cited in Cooperstock and Hill, 1982.

[150] One of the most widely used forms of psychotropic (mood-modifying) drugs in Canada; Valium is one of the more popular in this class of drugs.

[151] Anti-depressant drugs account for 3% of total drugs prescribed by physicians in Canada. Of these 85% are tricyclics, 12% lithium compounds and 2.5% monoamine oxidase inhibitors. (Penfold, 1986)

[152] Depending on Ourselves (Susan Penfold), 1986, p 14.

A variety of theories have been put forward as to why women receive such a high proportion of these drugs. Most are based on the belief that the condition for which they are most often prescribed - depression, found much more frequently in women than in men - is biochemically based. The scientific validation for this assumption is still in question. A disturbing aspect of this type of prescription drug use is that women can and do stay on such drugs for very long periods of time. Side effects of anti-depressants include appetite changes, insomnia, loss of interest in normal activities and sexual drive, loss of energy, and a decrease in the desire to initiate social interaction. Canadian psychiatrist Susan Penfold explains:

> " Entrenched beliefs in its efficacy, plus its actual lack of effect on people's problems or the depressing social conditions of their lives, lead to long-term use. Women who have called me... when I have talked about over-prescription, tell me that they have been on anti-depressants for between two and twenty years. They say that their doctors never question the original diagnosis, but switch them to another brand or type of anti-depressant if they complain that the drug is not helping. Rarely are they directed towards other ways of coping with, or overcoming depression."[154]

With respect to benzodiazepine use, Jessica Hill has noted that

> "... low income women and women with less education are more likely to use these drugs; being divorced, separated or widowed can contribute... tranquillizer use is higher among the unemployed and the underemployed and among women who remain at home than it is among those who remain in the labour force; use is also higher among the retired. [Characteristics of users include] low self-esteem, social isolation... physical health problems... loss or lack of socially valued roles... Even among people with chronic illnesses, women receive more tranquillizers and sleeping medication than their male counterparts."[155]

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[153] Various sources cited in Paltiel, 1987.

[154] ibid, p 14.

[155] Depending on Ourselves (Hill), 1986, p 17.

TABLE 3

TYPE OF DRINKER AND WEEKLY VOLUME OF ALCOHOL CONSUMED, BY AGE GROUP AND SEX, CANADA, 1985

	15 - 19 years		20 - 24 years		25 - 44 years	
	Women	Men	Women	Men	Women	Men
			%			
Never drank	24.0	22.2	7.5*	5.8*	10.7	4.1
Former drinker	3.9*	3.1*	3.5*	-----	5.0	5.5
Occasional drinker	27.1	17.2	23.5	6.6*	25.5	8.4
Current drinkers and weekly volume of alcohol consumed:						
Less than one drink	19.8	19.7	21.2	17.4	15.8	12.8
1-6 drinks	19.7	22.9	33.0	32.4	33.5	36.1
7-13 drinks	3.2*	6.5*	6.0*	20.4	6.6	17.2
14 drinks	-----	7.4	4.2*	16.1	2.5*	14.9
Weekly volume not known	-----	-----	-----	-----	-----	-----
Total current drinkers	44.6	56.9	65.3	86.4	58.6	81.3
Type of drinker unknown	-----	-----	-----	-----	-----	-----
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total population (000s)	945	993	1,166	1,193	4,039	4,021

	46-64 years		65 years and over		All ages	
	Women	Men	Women	Men	Women	Men
Never drank	17.5	8.3	36.4	12.4	16.9	8.1
Former drinker	7.0	8.1	12.5	16.0	6.3	6.5
Occasional drinker	23.1	13.4	20.3	15.1	24.1	11.1
Current drinkers and weekly volume of alcohol consumed:						
Less than one drink	15.5	12.7	8.4	10.9	15.7	13.8
1-6 drinks	25.8	31.3	14.2	22.4	27.5	31.6
7-13 drinks	7.9	13.4	5.4*	11.6	6.4	14.9
14 drinks and over	2.5*	11.7	2.6*	10.2	2.6	13.0
Weekly volume not known	-----	-----	-----	-----	0.3*	0.5*
Total current drinkers	52.2	69.7	30.6	56.2	52.5	73.8
Type of drinker unknown	-----	-----	-----	-----	-----	0.5*
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total population (000s)	2,461	2,376	1,407	1,065	10,019	9,649

*High sampling variability, use with caution.

Source: General Social Survey, Cycle One, Health and Social Support, 1985, Statistics Canada, Catalogue 11-612E

Poole notes that research indicates women in the workplace are more likely to abuse alcohol and women in the home are more likely to abuse tranquillizers.[156] The rate of women who are addicted to both alcohol and tranquillizers - commonly referred to as cross-addiction - is noteworthy. Again, accurate data do not appear to exist on the extent of cross-addiction in women, but conversations with staff in detox centres in Toronto revealed that the majority of women who are brought in or come in voluntarily to the two co-ed centres in Toronto are addicted to more than alcohol.[157]

2. Depression

Women experience depression twice as frequently as men and for one in ten women, this depression can be severe.[158] Because this condition is so prevalent, many theories have been put forward as to its origins or causes. Griffith-Kenney describes the typically depressed woman this way:

> " Mood disturbance and emotional distress are the dominant features of depression. The depressed woman is sad, blue, and gloomy. She feels helpless, hopeless, inadequate, and worthless. She may lose interest in work, friends, family and sex. Her energy level is low... Some women lose their appetites; others "go through food like a vacuum cleaner"... The woman may feel a heaviness in her head or chest or pain "as if my heart were breaking". She may cry easily and often... She may have difficulty concentrating and making decisions... Some women mask their sadness or despair, affecting a cheerful manner or even a kind of hectic gaiety... More commonly, everything about her droops - her mouth, her eyes, her posture. Tears come easily and she often sighs."[159]

Of all those mental health problems most common to women, the most research has probably been done on depression. Many of the findings are worth noting. [160]

•It is more common to women than men in all age groups and while the age of onset used to be reported as more frequently in a woman's forties, depression in young women is becoming more common.

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[156] Poole, 1985, p 97.

[157] Personal conversations between the author and directors of two detox centres in Toronto, February, 1987.

[158] Johnson, 1990; Paltiel, 1987.

[159] Griffith-Kenney, 1986, p 159.

[160] All of these have been noted in greater detail in Paltiel, 1987.

- One form of depression known as **manic depression** or bipolar depression (characterized by extreme mood swings - very high and very low) appears to be more common in men than women.

- Studies carried out in certain developing countries (Thailand, New Guinea, Taiwan and India) did not show the same female to male ratio (2 to 1) as that found in developed western countries.

- Women attempt suicide more often than men but men succeed more often than women.[161]

- Theories of a biochemical, hormonal or genetic origin for depression are not conclusive.

- Marriage appears to have a protective role for men and a detrimental role for women (i.e. of women experiencing depression, more are likely to be married; of men experiencing depression, more are likely not to be married).

- Women most at risk for depression are those at home with children under six.

One of the most frequently-quoted sources of information on women and depression is the work done by Brown and Harris in 1978. Their research was based on an extensive sampling of psychiatric patients and women in the community in which the hospital was located. They found that the loss of employment opportunities, low income housing and demeaning and unsatisfying work were strong contributors to depression in working class women. They also found that "working-class mothers were much more likely to suffer from a definite psychiatric disorder than middle-class mothers (1 in 5 compared to 1 in 20)"[162] and that severe life events involving long-term threats (such as loss of a parent as a young child) are major contributors to severe depression, sometimes not until many years later. We have also noted above that one of the main consequences of experiencing physical and sexual abuse is depression. Depression is also a common characteristic of women with a substance abuse problem.

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[161] In Canada, roughly 3/4 of all successful suicide attempts are made by men, and yet twice as many attempts are made by women. Women tend to opt for drug overdose as the most frequent means while men use more violent means such as hanging and firearms, suggesting that women leave more possibility of being "saved" or found before its too late. [Interestingly, American and Canadian patterns appear to differ, with women being just as likely to use firearms as men in the U.S.. In some developing countries, such as India, the rate of successful suicide attempts is higher in women than in men and the preferred method is drowning or burning. Many East Indian women's "suicides" are actually bride murders.] It has been postulated that the reason for so many unsuccessful attempts by women is because they are more inclined to send out distress signals indicating that they want help. Paltiel and others have suggested that women may be "held back by concern for survivors and that in the face of great adversity, they soldier on".

[162] Paltiel, 1987, p 247.

Post partum depression is a condition surrounded by a certain degree of controversy. Is it a normal reaction to a radical and rapid life change, purely a hormonal shift, or a combination of the two? Psychological research indicates that women who experience extreme post partum depression appear to be more likely to have experienced abandonment as a child or to have not had their needs met as a baby. Medical theories focus around hormonal imbalances. All women experience radical hormonal shifts after childbirth, and the assumption is that women who experience extreme depression have an endocrine (hormonal) malfunction. However, as Paltiel notes in her review of the medical literature, "... studies to date on hormonal changes ... during the post partum period have failed to demonstrate a direct link to post partum depression".[163]

In a feminist analysis of post partum depression, Debbie Field describes the condition:

> "Both the medical profession and the self-help movement use three classifications. During the first three weeks of their baby's life, somewhere between 60 and 75 per cent of women experience a day or a week of the "baby blues", with wild mood swings, unexplained rages and inconsolable tears... At the other end of the spectrum is post partum "psychosis", affecting one in 1,000 new mothers. These women have a complete breakdown with extreme suicidal or homicidal feelings, hallucinations and reality shifts. They are usually hospitalized and/or heavily medicated... Somewhere between these two, one in 10 women are estimated to have strong feelings of depression, anxiety and fear of homicide or suicide for six months to a year. Though they remain capable of functioning, they are often terrified that forced hospitalization, medication and potential loss of their children are right around the corner."[164]

Field argues against the tendency of making post partum depression into a medical condition, with ensuing medical interventions, the most common being the use of anti-depressants.[165] "Instead of seeing isolated motherhood as the cause of a woman's anxiety, the medical profession defines post partum depression as an illness requiring medical intervention... Though extreme cases may require drugs, the majority of women need counselling and strong consistent family/community support". She quotes Toronto therapist Hildi Wolfish, who specializes in the post partum phase, as suggesting that "pre-parenting anxiety" is a more accurate term to describe post partum depression. Field and others maintain that a certain degree of depression is a predictable reaction to a suddenly inflicted state of total responsibility for another human being, insomnia, insecurity and doubts about ones ability to parent, physical exhaustion and, in many cases, physical pain resulting from childbirth.

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[163] Paltiel, 1987, p 250.

[164] Field, 1989, p 17.

[165] As noted below, it is also not uncommon in Ontario to use electroconvulsive therapy (ECT) or "shock" therapy for extreme cases of post partum depression.

3. Anxiety

Along with depression, anxiety is one of the most common reasons women seek the help of mental health professionals, and they suffer from it three times as much as men.[166] Anxiety is characterized as a fear of the unknown and although a certain degree of it is a healthy normal reaction, it becomes problematic (i.e. help is needed) when "...[it] interrupts clear thinking, good judgment, adequate problem solving, or appropriate action".[167] The symptoms of "an attack of anxiety" include "apprehension, rapid heartbeat, clammy hands, sweating, shortness of breath, and an urgent need to urinate". These symptoms represent the fact that "our nervous and endocrine systems are stimulating some organs and depressing others as they prepare us to "fight or flee"".[168] In its extreme form (**panic attacks**) symptoms will also include dizziness, choking, trembling or shaking, nausea, numbness or tingling, chills or flushing and chest pain or tightness. It might also be accompanied by a fear of losing control or even dying.

One form of anxiety, known as **generalized anxiety**, is technically characterized as "unrealistic or excessive worry about more than one life circumstance on a daily basis for six months or longer".[169] For example, one might worry endlessly and unduly about their finances while having a perfectly stable and adequate income.[170]

Phobias are also considered a form of anxiety. A phobia is a persistent and unrealistic fear of either an external object (often animals, such as dogs, snakes, spiders, or mice) or a social or physical situation (such as being alone, being in confined spaces, or being in crowds). Phobias can range from quite mild to totally disabling.

One phobia, found far more frequently in women than in men (estimated at about four in five) is **agoraphobia**, which, literally translated means "fear of the marketplace" and more commonly as "fear of open spaces". The fearful situation usually involves crowds, confinement, being away from home. Agoraphobics suffer high levels of chronic anxiety, depression, depersonalization and panic attacks, while physical symptoms include sweating, dry mouth, and fainting. Johnson elaborates:

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[166] Johnson, 1990, p 271.

[167] ibid, p 272.

[168] Griffith-Kenney, 1986, p 166.

[169] Johnson, ibid.

[170] One may ask, given women's status, and particularly the situation of women who are isolated and discriminated against for other reasons, what is a "realistic" degree of stress?

> " Agoraphobia is the most disabling of the phobias. A person suffering from agoraphobia fears being away from her safe place, usually home, or her safe person, usually a parent or spouse. She also fears being in any place where she is confined - either physically or by social convention. If she cannot get away easily, she becomes very anxious. Agoraphobia can include a fear of driving, especially on expressways, through tunnels or over bridges. It can also include a fear of using public transportation, eating in restaurants, going to church, attending entertainment programs, or being alone."[171]

Griffith-Kenney further describes the woman suffering from an acute case of agoraphobia:

> "In severe cases, the agoraphobic becomes housebound and completely dependent on others. She may have to be accompanied everywhere or may refuse to leave her home at all. Her dependency prevents self-actualization and lowers her self-esteem, making her still more dependent. She is frustrated by her helplessness and discouraged at having to limit her activities. She fears losing control, having an anxiety attack in public, panicking, and feeling physically, emotionally, and mentally destroyed."[172]

Research has shown that most women suffering from agoraphobia are married, accounting for the popular press referring to the condition as "the housewives' disease".[173] Johnson has pointed out, however, that the condition is found just as frequently among employed women as women who are exclusively homemakers. Feminist analyses of the subject have continually noted that "in a larger societal context, the agoraphobic woman fits into the sex-appropriate female stereotype of fearfulness and dependency".[174] Others have seen it as an adult version of what very young children normally go through for a limited period of time as a part of normal psychological development - known as "separation anxiety".

Anti-depressants and anti-anxiety drugs are frequently used for treatment of agoraphobia, in some cases in conjunction with therapy which has the woman actively practising and confronting the actual situation she most fears. Some have argued that the medication serves only as a band-aid solution if the woman does not have strong social support - family or self-help groups - to help her overcome her condition.[175]

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[171] Johnson, p 275.

[172] Griffith-Kenney, p 169.

[173] A popular book on the topic is entitled Women Who Marry Houses.

[174] Mowbray et al, 1984, p 93.

[175] Mowbray et al, p 93.

A noteworthy aspect of agoraphobia is that it appears to be found only in Western countries.[176]

Psychiatric classifications for anxiety also include **obsessive-compulsive disorder** - "characterized by persistent and unwanted thoughts or impulses... such as an unrealistic preoccupation with dirt, contamination or germs" - and **post-traumatic stress disorder** (PTSD) - characterized as "the long-term adverse psychological consequences of severe stress such as active military duty, a natural disaster, physical abuse or sexual abuse".[177] The latter is found to be much more prevalent in women, and in men is frequently found in post-war veterans. Johnson notes that "previously mentally healthy women can and do develop this disorder in response to highly stressful life events". This comment raises the difficult question of whether we should label as a psychiatric disorder a response to a social situation which is itself "disordered". For example, feminists refer to "rape trauma syndrome" rather than PTSD to focus on the primary importance of the rape and to indicate that this reaction is not a disorder.

4. Schizophrenia

Dorland's Medical Dictionary[178] describes schizophrenia as "any of a group of severe emotional disorders, usually of psychotic proportions, characterized by withdrawal from reality, delusions, hallucinations, ambivalence, inappropriate affect and withdrawn, bizarre or regressive behaviour".

Schizophrenia appears to be diagnosed with roughly the same degree of frequency in women as in men although, as noted above, the research is not conclusive on this point. Paltiel (1987) notes that even though about as many women as men appear to suffer from the condition, most of the research conducted to date has been on males. Because women do not appear to predominate with this disorder, women and schizophrenia is not an area which has been widely researched by feminist scholars as well.

There is some controversy as to whether schizophrenia is genetic, biochemical, immunological or emotional in origin. Ontario Friends of Schizophrenics staunchly maintains that it is not emotional in origin and write frequently of the degree to which families have suffered as the result of treating it as the problem of a dysfunctional family. Executive Director of OFOS, June Conway Beeby, speaks of the degree of mother-blaming which goes on in talking about schizophrenia, in which she claims that mothers are being blamed due to confusion about the physical disease component of this illness. Beeby notes that "medical research has arrived at several possible explanations for the factor that triggers schizophrenia in a susceptible person... lots of evidence for genetic, biochemical, viral and immunological theories" and of British research which has located the gene region which causes schizophrenia.[179] Still others maintain that "the schizophrenic is a person who has apparently been unable to find a way of adjusting to some painful situation and so has rejected the outside world in favour of her own inner vision".[180]

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[176] Goleman, D., 1989.

[177] Johnson, p 275.

[178] Twenty-third edition, 1982.

Margaret Gibson, author of *The Butterfly Ward* wrote this in her foreword to a Canadian book on dealing with schizophrenia:

> " I believe that I have been a schizophrenic since I was a child. Schizophrenics have lucid states, but when they are not lucid, life is sheer hell: raging all day and spending the night on a bed in a semi-catatonic state, hearing voices and seeing things that no one else can hear or see, the sharp edge of a razor ripping open flesh like a ripe grape, the smell of burning flesh. And all this is you but not you - at that moment, illusion is all that exists; you have opened the door into another reality to which you alone hold the keys."[181]

According to the chief psychiatrist at Mount Sinai Hospital in Toronto, Dr. Mary Seeman, the onset of the symptoms begin, on average, at age 18 in men and age 25 in women.[182] Seeman also maintains that "the symptoms in women often involve mood swings from depression to elation, while men become more emotionally flat, apathetic and negative".[183]

The main features used to establish the diagnosis of schizophrenia include delusions (such as having special powers, persecution, being influenced by an outside source), auditory hallucinations (thoughts heard out loud, voices talking about you), disturbances of feeling,(inappropriate display of emotion or a limited range of emotion), and physical symptoms (slowness of movements, withdrawal, reclusiveness, severe over-excitement and ecstasy, adoption of strange mannerisms).[184]

In a conversation with June Conway Beeby from Ontario Friends of Schizophrenics, she noted that while there is little information about women and schizophrenia, the degree to which it is women - in some cases considerably older women - who are looking after children very ill with this disease, is "very much a women's issue".

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[179] Beeby, 1988.

[180] Fishbein, 1966, p 407.

[181] Seeman, 1982 (Foreword).

[182] Dunlop, 1987.

[183] ibid.

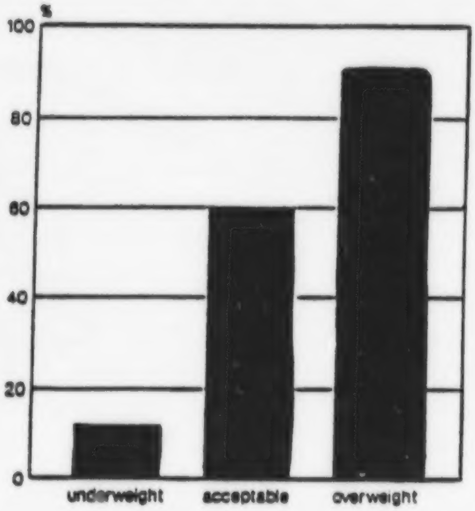
[184] Seeman et al, 1982.

5. Eating Disorders

Long seen by traditional psychiatry as a psychiatric disorder requiring psychiatric intervention, eating disorders, over the last 15 years, have come to be seen as "the extreme of a continuum which today encompasses most women in North American society".[185] In Canada, as in most of the developed world, there are tremendous cultural pressures on women to achieve an artificially constructed notion of an ideal female body form. Media images continually spell out the message that thin is best, thin is attractive and thinness will win you rewards. Fashions are designed with the slim figure in mind and there is a strong stigma against being overweight. Women are socialized not only into being critical of their own body weight but that of other women.

TABLE 4

% WOMEN WHO WOULD LIKE TO LOSE WEIGHT, BY WEIGHT RANGE (USING BMI)



Weight Range (computed from BMI)

Source: Canada's Health Promotion Survey

A survey of the health promotion habits and behaviour of Canadians in 1985 found that over 60% of women would like to lose weight. Of that group, over 80% were overweight, but an astonishing 60% were of an acceptable weight and over 10% were actually underweight. (see Tables 4 & 5). These statistics give some indication of the extent to which women in Canada are preoccupied with their weight. The National Eating Disorders Information Centre, located at the Toronto Hospital, note one study which showed that half of the nine year old girls in one school were already dieting.

The preoccupation which women have with weight is evidenced by the fact that most women go on and off diets throughout their adult lifetime, despite the fact that 95% of those who diet regain their weight and 90% gain back even more than they lost. Once on the diet roller coaster, Brown and Forgay note that

> "... women enter into a more vigilant policing of their bodies and ever more desperate attempts to lose weight... cyclical starvation and bingeing, fasting and jaw wiring, gastric and intestinal bypass surgery, liposuction and amphetamine abuse take their place among the many ways

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[185] Brown and Forgay, 1987, p 11.

women's bodies are mutilated in an effort to attain the ideal of beauty".[186]

Smaller numbers (roughly 5%) of women suffer from the most severe form of this preoccupation with weight - **anorexia nervosa** - while a slightly larger number (roughly 15%) suffer from **bulimia**. Both of these conditions are characterized by an intense fear of weight gain. Gaining weight represents a loss of control and many anorexics and bulimics believe that this is the only area of their life over which they have control. In anorexia, this is manifested by severe weight loss and in bulimia, by periods of binge eating followed by attempts to purge the food from the body (by vomiting, taking laxatives, diuretics or enemas or by fasting). Of individuals who suffer from this extreme preoccupation with weight, between 90% and 95% are women.

Although eating disorders appear to be more common among adolescent females of middle and upper class homes, it is now believed that the disorder cuts across all age and class boundaries[187]. The effects of these disorders can be physically debilitating and the death rate from anorexia nervosa is one of the highest in psychiatry - 10 to 20% of those who develop it will die from it.[188] Its incidence also appears to be on the rise. A woman suffering from anorexia nervosa actually has a fear of being obese, comparable to the phobias discussed above. She does not realize how underweight and undernourished she actually is and "even when down to 80 pounds, the anorexic will find parts of her body that still "need work" and will often complain that she "feels fat"".[189] She may also be obsessed with exercising in order to burn off more supposed fat. She usually has menstrual irregularities or no menstrual periods at all (amenorrhea). Her heart rate, body temperature and body metabolism are lower than average and her general appearance looks quite unhealthy.

Mowbray et al note that with anorexia,

> "... success or failure at weight control is a "symbol" of the ability to control life in general. The success is experienced as a pleasure in disproportion to all physical and social benefits while failure is experienced as "profoundly demoralizing". Patients often feel terror at giving in to an impulse to eat."[190]

A variety of factors have been proposed in the literature and research on anorexia nervosa which are believed to predispose someone to this condition. Some of these are at the individual level (such as identity problems, immature cognitive development, perceptual disturbances), others at the familial level (alcoholic fathers, exaggerated parental demands) and others at the cultural level (as noted above, a strong societal pressure on women to be thin). A fear of growing up to be an adult woman in a world that is seen as dangerous and lacking choices may also be a predisposing factor.

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[186] ibid, p 13.

[187] Paltiel (1987) asks whether it is in fact more prevalent in high socioeconomic status females or whether it is only more likely to be recognized and treated in this group.

[188] Fact sheet from the National Eating Disorders Information Centre, Toronto.

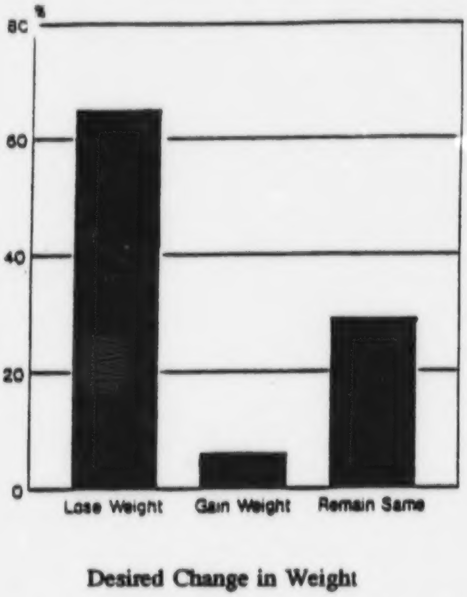
[189] National Eating Disorders Information Centre booklet on eating disorders.

[190] Mowbray et al, 1984, p 83.

Bulimia is considered a form of anorexia nervosa and the two have many characteristics in common. The "binge" component of bulimia consists of taking in large quantities of food, usually junk food and food very high in caloric count and then purging the body of the food by various means. Mowbray et al elaborate:

TABLE 5

% WOMEN WHO WOULD LIKE TO....



Source: Canada's Health Promotion Survey, 1985

" The condition is particularly prevalent in girls of high school and college age, particularly among those oriented towards academic achievement and a traditional life-style. Solitary bulimics often go unnoticed for years, because, unlike anorexics, their weight stays within normal limits and they appear healthy. For others, bulimia is shared socially, e.g. girls who are "barf buddies" stuff themselves with food and then go to the bathroom together to vomit."[191]

Bulimia can have serious physical consequences, including a loss of essential nutrients, particularly potassium from the excessive vomiting, gastrointestinal disorders, dental problems, and menstrual problems. Some literature has shown a link to a history of emotional and sexual assault and abuse in bulimics.

Most literature on the subject emphasizes the importance of therapy - individual, family and group - in the treatment of anorexia nervosa and bulimia. Anti-depressant drugs are also often used in conjunction with the psychological therapy. The National Eating Disorders Information Centre and feminists writing on bulimia have criticised the use of anti-depressants in the treatment of this disorder.

As noted above with agoraphobia, the condition of anorexia nervosa appears to be found only in Western countries.[192]

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[191] ibid, p 84.

[192] Goleman, 1989.

6. Borderline Personality Disorder

The diagnostic term of borderline personality disorder is said to account for close to a quarter of all admissions to psychiatric hospitals.[193] Symptoms include strong reactions to mild stimuli, episodes of anger, chronic dysphoric[194] mood, feelings of emptiness or boredom and intermittent episodes of major depression. Herman notes that "consistent difficulties in impulse control result in behaviours that are destructive to self or others, including substance abuse, risk-taking, promiscuous or perverse sexual activity and violent outbursts". Self-mutilation and suicide attempts are very common in those diagnosed with borderline personality disorder. She adds that they are "often described as unable to tolerate being alone and to seek emotional involvement with others actively. However, the relationships they establish are intensely conflictual and unstable". Attachments with others are idealized and result in inevitable disappointment, rage and withdrawal.

An overwhelming majority of individuals diagnosed with borderline personality disorder are women - anywhere from 67 to 87%.[195] A significant number have also been victims of abuse as children and girls are at two to three times greater risk of sexual abuse as boys. Herman notes that in all the literature on borderline personality disorder, little mention is made of this alarming link, and the feminist therapy and research communities are turning increased attention to this connection.

Herman and Rivera have both noted that there are many similarities between the characteristics of borderline personality disorder and **multiple personality disorder**. This latter disorder, which has been sensationalized in the popular media [196] and has been described as being "almost invariably an outcome of severe childhood abuse... particularly the sexual abuse of little girls".[197] As with borderline personality disorder, the overwhelming majority of those diagnosed with the condition are women - as many as nine out of ten. Rivera too remarks on the astonishing omission about this link in the traditional psychiatric literature on multiple personality disorder. She argues for the need to view this phenomenon, which she describes as "one of the most severe personal consequences of childhood sexual abuse", not only as a psychiatric disorder but as a feminist concern. In Rivera's experience as a therapist working with women with multiple personality disorder, she has found that "it is very common for their vulnerable child personalities and their seductive and/or compliant personalities to be female and their aggressive protector personalities to be male", something which she describes as being "powerfully illustrative of the construction of masculinity and femininity in our society".[198]

If multiple personality disorder can be viewed as a coping mechanism resulting from extreme childhood trauma, it may not need to be viewed so much as a disorder but rather an indication of the profound dichotomies with which many women must contend.

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[193] Herman, 1987, p 111.

[194] Dysphoria is described as "disquiet, restlessness, malaise".

[195] Herman, ibid, p 116.

[196] Witness the popularity of films such as Sybil.

[197] Rivera, 1989, p 24.

[198] ibid, p 27.

Women and Traditional Psychiatry

Judi Chamberlin, American author of *On Our Own*[199], a book about the problems in the existing mental health system and about patient-controlled alternatives, and who herself was a psychiatric patient, was asked in an interview whether she felt the current mental health system was harmful for everybody. She replied: "It has that potential. It reinforces the sense that what's wrong with you is wrong with *you*. There are a lot of things that are wrong out there which make us unhappy, and I really think that most people are going to feel much better about themselves when they get involved in action rather than "fixing themselves." Of her experience in psychiatric institutions, she writes "It was years before I allowed myself to feel anger at a system that had locked me up, denied me warm and meaningful contact with other human beings, drugged and so thoroughly confused me that I thought of this treatment as helpful".[200]

A vast array of treatments exist to respond to the biomedical view of mental illness. While many women have likely been helped by psychiatry, some have argued that psychiatry's "treatment" methods simply serve to numb and negate women's everyday realities rather than help to actively change them. The Feminist Therapy Group of Toronto has summarized this situation:

> "... women are particularly oppressed as psychiatric patients. Women who are unhappy in their roles as wives and/or mothers, women who are lesbians, women who are struggling to define their lives for themselves are often labelled "sick" and committed to institutions by husbands, parents, children and friends. In hospital, a woman feels naked, stripped of her identity with no credibility, no privacy and no control over her life. She is constantly observed and her behaviour is always perceived as a symptom of her illness."[201]

An additional concern which is only recently gaining some attention is the sexual abuse of women patients by their psychiatrists. When this occurs, the very institution which a woman thought was going to help her with her problems ends up making her a victim. Canadian data is still being gathered on the incidence of this form of malpractice, but American data show that 4% to 14% of male therapists admit to sexual contact with their client, in the belief that this will be "therapeutic" for the patient. In a workshop on this issue at the women and mental health conference in Banff in 1989, psychologist Jerri Wine, member of the Coalition for the Advancement of Sexual Ethics in Therapy, stated that "sexual relationships with clients are unethical [and] take advantage of the vulnerability and trust and respect for the therapist that clients must experience if therapy is to be effective". She argued that this form of exploitation by therapists "echoes the sexual exploitation of girls and women in the patriarchal family... the socialized belief by men that they have the right to control the women in their lives".[202] The Coalition is currently attempting to gather Canadian data on the incidence, patterns and characteristics of abuse by therapists.

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[199] In recognition of her important contribution to the field of self help for ex-psychiatric patients, a group based in Toronto has called itself On Our Own.

[200] Shapiro, 1984.

[201] The Feminist Therapy Support Group, 1982, p 26.

The practice of administering **electroconvulsive therapy** (also known as ECT or shock treatment) in general and psychiatric hospitals throughout Ontario is an extremely contentious issue which has been addressed by feminists and advocacy groups for ex-shock treatment patients. The practise's proponents and opponents have equally strong views. In the United States, the National Institute of Health's panel on ECT stated in 1985 that they not only backed its continued use but one member suggested that it is "currently being underused".[203]

In Ontario, the Minister of Health in 1984 established an Electro-Convulsive Therapy Review Committee in response to a controversial court case which exposed that shock may be being used for questionable purposes and against people's will. The establishment of the Committee was also a response to the Toronto Board of Health calling for a moratorium on further use of the treatment until further investigation of the procedure was done. The panel initially had no consumers on it until the Minister placed one representative following great public outcry.[204] The panel learned that accurate statistics on the use of the treatment in Ontario were extremely difficult to come by. The report was ultimately shelved and its use continues in Ontario's general and psychiatric hospitals. One fact which has been determined about its use is that two to three times as many women as men have this procedure performed on them.[205] Simmons, in his study of mental health policy in Ontario has noted that "typically, when new treatments were introduced, women were selected as the guinea pigs".[206] Many personal testimonies of women who have been given the treatment for such conditions as post partum depression and more generalized depression have appeared over the years in issues of *Phoenix Rising*, a publication produced by ex-psychiatric patients. Concern about its widespread use in women was mentioned in the report of the Canadian Mental Health Association' Women and Mental Health Committee in 1987:

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[202] At the same conference, American psychologist and feminist writer Phyllis Chesler noted that "Women seeking help from male mental health professionals recreate what goes on in the family".

[203] Medical World News. July 8, 1985.

[204] Public response to the issue over the years has been spearheaded by the Coalition to Stop Electroshock in Ontario and the Ontario Psychiatric Survivors' Alliance.

[205] Smith and Richman, 1984.

[206] Simmons, 1990, p 16.

> "...The use of this physically intrusive and damaging treatment cannot be attributed solely to the greater incidence of depression in women, since more women than men receive ECT in every diagnostic category."[207]

> The origin of the treatment is worth considering:

> " Because somebody observed that the mood of epileptics tended to lift following a seizure, researchers believed that the seizure could be therapeutic. Initially, [certain clinicians] introduced chemicals to do the job. Meanwhile, in fascist Italy, Cerletti and Bini were working on a machine that would induce these convulsions[208] through electricity. The initial experiments on animals failed because most of Cerletti's subjects died. He soon discovered that this was caused by putting one prong into the animal's mouth and the other into the anus - thus allowing electricity to go through the heart. Cerletti first improved his idea from observing the behaviour of hogs given shock while in the slaughterhouse. He noticed how the shock was administered at either side of the animal's forehead. This caused the hogs to go into convulsions, slip into a coma, and feel no pain as they were slaughtered. He noted that when he tried administering shock this way his own animals survived and were quite able to resume normal activities thereafter. He presumed that there was no harm done and that such convulsions could be given to humans."[209]

It is not known exactly how the procedure works, although its advocates maintain that it has helped many people who are severely depressed. Short term memory loss appears to be common to all recipients of the procedure (as one woman put it "You forget that you were depressed or what it was you were depressed about.") and there is concern that irreversible memory loss and brain damage also occur. Other complications of the procedure include circulation problems, tooth damage, vertebral compression fractures, peripheral nerve palsy, skin burns and prolonged apnea.[210]

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[207] CMHA Report, 1987, p 59.

[208] Convulsion is described in the Report of the Electro-Convulsive Therapy Review Committee as follows: "As produced by the electrical stimulus in ECT, it is similar to the grand mal seizure in epilepsy. It consists of: 1) immediate unconsciousness, 2) a strong contraction of skeletal muscle for several seconds, 3) clonic movements, ie. intermittent contraction and relaxation of skeletal muscles lasting a longer period. Among other features are brief cessation of breathing (apnea), relaxation of bowel and bladder sphincters, and evidence of stimulation of the autonomic nervous system".(p 101)

[209] Browne, 1990, p 52.

[210] Apnea: cessation of breathing.

In an article on women and psychiatry, self-help group activist and writer Angela Browne outlines the work that has been done over the past 15 to 20 years by the ex-psychiatric patients' movement to lobby for change. She outlines the work done for and by women in self-help groups as a successful and low cost alternative to traditional psychiatry. She recognizes that community-based alternatives may not provide the answers for all mentally ill women, but certainly for a majority. For those who must be institutionalized, she argues that

> " We must oppose potentially harmful treatments, often administered to people in the name of so-called biological psychiatry. Those we refer to as mentally ill should have the same rights as everybody else."[211]

Women and Therapy

In a discussion of the nature of the psychotherapeutic relationship, Johnson and Ferguson comment that "the greatest healing power is in experiencing the sense of being heard and responded to in a consistently empathic and supportive way". They go on to say that the traditional psychotherapeutic relationship, based on the Freudian model, is not characterized by these qualities; in an effort to remain "neutral" and convey the impression of being "the expert in charge", the therapist remains relatively non-reactive, saying very little except to encourage the patient to talk. They note that "patients rarely find this helpful... It does not feel like neutrality. It feels as if nobody is there."

The women's movement over the past twenty years has had a tremendous impact in "feminizing" the therapeutic world and in raising awareness about the social nature of many of women's so-called psychiatric problems. Johnson and Ferguson contrast the female-oriented model as being far less neutral than the psychotherapeutic model described above. "Women are trained to nurture, and a female-influenced psychology reflects this strength".[212] The female-oriented model of therapy is seen as being more conducive to change in the patient since the empathic and supportive character of the relationship is, by nature, more healing. As they note, "People usually come to therapy because they hurt".

An effort is made in the literature to distinguish between female-oriented or feminist therapy and a female therapist. That one is female is no guarantee that one practises feminist therapy. Similarly, men can practise feminist therapy, or what some have referred to as non-sexist therapy (Webster, 1988).[213] Although some see feminist therapy and non-sexist therapy as synonymous, Webster distinguishes between the two in the following way:

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[211] Browne, 1990, p 21.

[212] Johnson and Ferguson, 1990, p. 12.

> " **Non-sexist therapy** is seen as that which attempts to avoid sex-role stereotyping which discriminates against either sex. **Feminist therapy** is seen as going further in questioning the power relationships inherent in any therapy process and calling for new ways to provide an egalitarian experience in therapy which might facilitate learning about women's experiences, rather than telling women what their experiences are or should be."[214]

By way of a further distinction on this point, Corinne Squire[215] refers to both of these types of therapy as involving feminist psychology. She views non-sexist therapy as the dominant, egalitarian form of feminist psychology which tries to work within traditional psychology and sees feminist therapy as having developed outside the conventional discipline.

Perhaps one of the best illustrations of the distinctions between feminist therapy and traditional therapy is in the area of treatment following sexual assault. In research conducted by Hutchinson and McDaniel (1986), the differences are well summarized:

> " In conventional therapy, sexist attitudes, individualization of the problem, victim-blaming, control over the woman by the therapist, defining rape as a sexual act and re-labelling her reality are common themes. In contrast, sexual assault victims who have experienced feminist therapies seem confident they have found a framework with which to explain their victimization, feel relieved of guilt surrounding the incident and report the emotional support and understanding which the group approach especially provides...Women... refer to the non-judgemental atmosphere, the unconditional acceptance, the validation of the experience and the feeling of belonging, understanding, encouragement and security..."

The authors go on to say that traditional therapists in these situations act as "legitimators of the existing belief system" because our culture "has not yet been able to face the reality of sexual assault, rape and incest". They discovered that traditional therapists "reconstruct the woman's perception, rather than facing the possibility that sexual assault is rampant and real" and go on to describe this experience for women as "crazy-making of the first order".

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[213] It is noteworthy, however, that as long ago as 1879, the idea was brought forward that women were best treated by other women in matters of mental health. Dr. Margaret A. Cleaves maintained that " insanity in women would be better understood if insane women were placed in the charge of "physicians of their own sex"" (Geller, 1985, p. 1056).

[214] Webster, 1988, p.18.

[215] Significant Differences: Feminism in Psychology.

While the appearance of alternatives to traditional psychiatry have been welcomed by women, a consistent concern has been that many of them are not covered by our provincial health insurance plans. The result is that if one can afford it, one can always find it, but if not, the waiting list for subsidized services is extensive.[216] Some feminist therapists maintain sliding scales to accommodate women who can not afford their regular rates, but as counsellors at the Women's Counselling Referral and Education Centre in Toronto have noted, many women simply can't afford even the bottom rate.

The model of self help, which provides a reasonable alternative to one-on-one therapy for some women, is a solution which requires more development and government support. Models for less costly alternatives for ex-psychiatric patients such as "the clubhouse model" and "transitional employment programs" are receiving more support and allowing women more control over their lives.[217] However, all women must have access to broad range of services, otherwise poor women will continue to receive very limited attention.

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Comments made in these two preceding chapters are not meant to leave the impression that all individuals trained in psychiatry and related disciplines will do women more harm than good or that all feminist therapists are completely ethical and the answer for all women. However, some of the major tools of modern psychiatry - medication, use of the DSM IIIR and the authority to institutionalize - have been shown to sometimes further women's victimization. On the other hand, the backbone of feminist therapy - a more holistic approach to a woman's problems with a recognition of society's ills which contribute to women's psychology as well as a validation of her experiences - would appear to go further in helping women to make true and lasting change as well as working to change the social organization of women's lives.

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[216] For example, the Brief Psychotherapy Centre for Women, a service for women using non-psychiatric health professionals through Women's College Hospital in Toronto, currently has a waiting list of ten months - hardly a solution for a woman who is currently in crisis.

[217] These types of organizations are described in more detail in Angela Browne's article in the Spring, 1990 issue of Healthsharing magazine.

Women and Mental Health in Ontario

The past twenty years in Ontario have seen a major shift away from the institutionalization of individuals with a mental illness into the community. Unfortunately, the move was primarily motivated by a need to cut costs[218], and less motivated by an understanding of the harms done to individuals by putting them into institutions. Rachlis and Kushner, in their analysis of the Canadian health care system comment:

> " What had seemed at first like a very humane policy turned sour. These emotionally fragile people were suddenly out on the streets without adequate community services to support their adjustment to independence. The government's failure to reallocate enough resources for supportive housing, job training, and crisis intervention for this vulnerable population is a well-documented disgrace."[219]

This move also led to a tremendous burden on the social service system and an increase in the population of people out in the community on heavy doses of medication with little emotional support. Many of these people are women, often living in unsafe boarding homes in large urban centres.

In 1976, a Program Advisory Group, conceived in the Ministry of Health was established in part to create new initiatives toward community based programs. In 1987, the Community Mental Health Branch was established. Today, the classification for mental health in the breakdown for the Ontario health budget receives only 5% of the province's total budget.[220] Within that branch, there is no specific policy on women's mental health and funding of women's mental health programs has been piecemeal and not with a long term goal in mind.[221]

The Minister of Health formed a working committee in 1987 to develop a framework for the delivery of community mental health services in Ontario (chaired by Robert Graham and hence referred to as the Graham Report). The report has been cited by many as being a move in the right direction with respect to redressing the imbalance of funding for community based services for the mentally ill. It represents a definite effort to improve the very problematic situation which was left behind by de-institutionalization.

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[218] Rachlis and Kushner, 1989, p 313.

[219] ibid.

[220] Ontario's Health Care System: Some Facts and Figures, April, 1989.

[221] This is based on statements made by the Director and the past-Director of the Community Mental Health Branch in a meeting with the author and members of the Social Issues Committee of the Ontario Advisory Council on Women's Issues, 1989.

Although the committee was specifically mandated with "[advising] the Minister on the initiatives required to meet the needs of special target populations including women, youth, the elderly, ethnic and Native groups"[222], this responsibility was ultimately passed off to proposed Area Mental Health Advisory Boards and the issue of women's special mental health needs and issues received less than one page of attention in the final report.

As a result of the Graham Report, a draft discussion paper proposing a Community Mental Health Act was produced and was followed by a series of consultations around the province which concluded recently. The proceedings from those consultations is currently being pulled together. One source affiliated with the process noted that the issue of women came up very infrequently.

In a similar vein, another report commissioned by the Minister of Health entitled *A Framework for the Response to Drug and Alcohol Problems in Ontario*, which was released in 1988, also failed to address the unique needs of women with addiction problems. The authors of the Framework acknowledge that "the model does not predict the need for services for special sub-groups of the population (e.g. youth, women, Native people, elderly)" and offers as an explanation that this is due "... in part, to the lack of data on the prevalence and severity of alcohol problems in these sub-groups".[223] It is worth noting that in a recent series of submissions regarding funding for a Toronto women's detox centre, participating hospitals managed to accumulate a fairly sizable body of literature on the prevalence and severity of alcohol problems among women.

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[222] The Graham Report, p 1.

[223] Mauro, 1988, p 2.

Conclusion

In this examination of women and mental health, we have seen the extent to which the social organization of women's lives is so closely intertwined with the development of mental health problems. More specifically, we have seen that the less autonomy and control a woman has over her life, the less likely she is to enjoy a true state of mental health and well-being.

When women seek professional assistance, many experience additional problems due to lack of gender sensitivity on the part of these professionals. More women than men are diagnosed with a variety of mental health problems and women also outnumber men in being prescribed medication and other forms of "treatment".

During interviews for this report, many individuals knowledgeable about women and mental health, recommended a total overhaul of our mental health care system. (Some even called it our mental illness system.) Others called for a transformation of our payment system to allow total coverage of feminist therapists in various health disciplines. But the one point on which everyone appeared to agree was the need to change the larger social factors which shape women's mental health.

Pay equity. Child care. An end to violence against women. Safe and equitable working conditions. Men's assumption of more responsibility in the home. Women in politics. Teaching the value of women and women's roles from a very young age. Women in positions of power. To work on the achievement of any of these goals is to work towards potential improvement of women's mental health. Many of those interviewed felt that **unless** we work on the improvement in the quality of women's lives, we will never make any real change in their mental health. Some saw new programs, new treatment modalities and improved mental health services as merely being band-aid solutions to much larger societal problems.

A feminist perspective on mental health specifies that so-called mental health professionals themselves must be working on these larger societal changes. An illustration of this would be a group of feminist therapists lobbying the provincial government for improved child care services. Furthermore, therapists working with women must involve every effort to guide them towards their own sense of empowerment and personal control over their lives. The work at the personal level in the therapeutic relationship and the work at the larger political level are seen as being equally important.

At the same time, we must also look at the immediate difficulties faced by women suffering from debilitating mental health problems. The problems faced by women who enter Ontario's psychiatric system require a full investigation. The lack of gender sensitivity in the training of mental health professionals must be addressed. The two-tiered system in mental health services - where only those who can afford it can see the therapist of their choice - needs to be re-examined in light of Ontario's commitment to universal access to health care.

Women as consumers of mental health services must be given the information and the tools to understand that they have full right to expect better than what they are getting, to question practices which seem suspect, discriminatory, or humiliating. The lack of attention to women and other minorities in the provincial report *Building Community Support for People: A Plan for Mental Health in Ontario* must be seen as simply unacceptable. Any mental health plan in Ontario which considers the needs of women must be a plan for social action. Changes are needed in the existing health care system. But equal priority must be given to larger systemic changes which will improve the quality of women's lives.

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Glossary

The following definitions are taken from Dorland's Pocket Medical Dictionary (Twenty-Third Edition), and glossaries provided in Fishbein (1966) and Clark (1985). Definitions were not included for those terms which were already defined in the context of the report.

addiction The habitual use of alcohol, drugs and similar substances; known to medical science as pharmacopsychosis.

affective disorders A psychiatric term used to describe mood disorders characterized by marked sustained changes of mood, to the extent that the person is disabled in her day-to-day functioning.

alcoholism Poisoning by alcohol, or the severe results of prolonged and excessive consumption of alcohol

amenorrhea The failure of menstrual periods to start by the expected age or the cessation of menstrual periods once they have started; can be the result of extreme dietary change, medication a tumour, chronic lead poisoning or stress.

antidepressant drugs Drugs able to lessen or remove symptoms of a depressive condition.

biochemical To do with the chemistry of living tissue.

clinical psychiatry The branch of psychiatry concerned with the assessment and treatment of patients.

clinical research Research on live patients [as opposed to research on animals or research using only specimens of tissue].

clinical trials Trials of methods of treating patients.

delusions False beliefs manifested by someone with a mental disorder such as schizophrenia.

depression A term used to describe a) normal sadness b) abnormal sadness that is a symptom of an underlying psychiatric disorder or systemic medical disorder or c) a disorder in itself.

electro-convulsive therapy A medical procedure in which two or more electrodes are placed on the sides of the head and a measured electrical current is passed through the brain inducing a grand mal convulsions.

hallucination An impression, involving any of the five senses, without actual basis in fact ("seeing things", "hearing voices",etc).

morbidity The quality of disease of being diseased.

pathological Diseased, abnormal.

pharmacotherapy Drug treatmentment.

placebo effect The effect of any treatment based entirely on the person's expectations, not on the known specific effect of the treatment. Both known effective and known ineffective treatment can produce placebo effects.

psychiatry The branch of medicine dealing with the study, treatment and prevention of mental illness.

psychoanalysis A method of diagnosing and treating mental and emotional disorders through ascertaining and analyzing the facts of the patient's mental life; developed by Sigmund Freud.

psychosis Any major mental disorder of organic or emotional origin marked by derangement of personality and loss of contact with reality, often with delusions, hallucinations or illusions.

psychotherapy Any treatment using psychological (as opposed to physical) methods.

psychotropic drugs Drugs with a primary effect on mental functioning.

schizophrenia Any of a group of severe emotional disorders, usually of psychotic proportions, characterized by withdrawal from reality, delusions, hallucinations, ambivalence, inappropriate affect and withdrawn, bizarre or regressive behaviour.

Appendix A

Individuals and Organizations Contacted or Interviewed in the Process of Writing this Report

Dyane Adam
Dept. of Psychology
Laurentian University, Sudbury

Helen Angus
Policy and Planning Branch
Ministry of Health, Toronto

June Conway Beeby
Ontario Friends of Schizophrenics, Toronto

Irene Beer
Pinecrest-Queensway Community Centre,
Ottawa

Boston Women's Health Book Collective
Boston, Massachusetts

Dr. Clare Brant, Director
Native Mental Health Association of
Canada, Shannonville

Paul Capon
Ontario Native Women's Association,
Thunder Bay

Dr. Ian Casson
Former Medical Director, Zone Hospital
Sioux Lookout

Pam Dunk
Ontario Women's Directorate,
Thunder Bay

Grace Francis
Nova Scotia Native Women's Association
Halifax, Nova Scotia

Nancy Huneault
Pinegate Addiction Service
(Network North), Sudbury

Patti McGillicuddy
Social Worker, Counsellor
College Street Women's Centre, Toronto

Sarah Melvin
Windigo Tribal Council, Sioux Lookout

Diane Nannarone
Policy Adviser
Women's Health Bureau
Ministry of Health, Toronto

Freda Paltiel
Senior Adviser, Status of Women
Health and Welfare Canada, Ottawa

Eileen Quinn
Mental Health Program Services, Toronto

Irit Shimrat
Phoenix Rising, Toronto

Hugh Tapping
Ontario Psychiatric Survivors Alliance,
Toronto

Dr. Margaret Thurling
Women's Clinic, Department of Psychiatry
The Wellesley Hospital, Toronto

Mary Beth Valentine
Psychiatric Patient Advocate Office,
Toronto

Kathleen Whipp
School of Social Work, Carleton
University, Ottawa

Heather Woodbeck
Northwestern Ontario
Women's Health Information Network,
Thunder Bay

Women's Post Treatment Centre
Winnipeg, Manitoba